MedBen
health. benefits.

SEND CLAIMS DIRECTLY TO:
MedBen
P.O. Box 1009 • Newark, Ohio 43058-1009
(740) 522-8425 • Toll-Free (800) 423-3151

DISABILITY CLAIM FORM

Statement of Employer

Employee's Name _____ Social Security No. _____ Div. No. _____

Benefit Plan _____ Date of Employment _____ Eff. Date of Plan _____ Eff. Date of Last Change _____

Percentage of premium paid by Employer _____ % Salary continuance or sick pay $ _____ Paid from _____ through _____

Was coverage in force when disability began? ..... ☐ Yes ☐ No Date Employee last worked _____

Is Employee's coverage still in force? ..... ☐ Yes ☐ No If "No", give date of termination _____

Has Employee returned to work? ..... ☐ Yes ☐ No If "Yes", give date returned _____

Type and Amount of Benefit Claimed: ☐ **Long Term Disability $** _____ ☐ **Short Term Disability $** _____ ☐ **Life Coverage During Disability $** _____

Employee's Salary Monthly $ _____ Weekly $ _____ Eff. Date of Salary _____

Employer _____ Group/Account No. _____

Date _____ By _____ (Signature) Title _____ Telephone No. (_____) _____ (Area Code)

Instructions to Employee

(1) This form is to be filed as soon as it appears that you will qualify for disability benefits.
(2) Complete the **Statement of Employee** below and the **Authorization for Release of Information** on the following page.
(3) Have your physician complete the Attending Physician's Statement on the reverse side.
(4) Return form to your Employer.

Statement of Employee

Your Name _____ Telephone No. (_____) _____ (Area Code)

Your Occupation _____ Date of Birth _____ Social Security No. _____

When did you become wholly unable to work? Date _____ Hour _____ A.M. _____ P.M.

Have you been continuously disabled since you became unable to work? ..... ☐ Yes ☐ No

If "Yes", approximately when do you feel you will be able to resume work? _____

If "No", when did you again become able to work? Date _____ Hour _____ A.M. _____ P.M.

Is disability due to ☐ accident ☐ sickness? If accident, describe, including date and place. If sickness, when did symptoms first appear?

_____

Have you been hospital confined for this disability? ☐ Yes ☐ No If "Yes", when? From _____ To _____

Name of Hospital _____ (Address)

Did disability result from employment? ☐ Yes ☐ No If "Yes", amount of Workers' Compensation benefit $ _____

Do you have disability insurance with other companies? ☐ Yes ☐ No If "Yes", give names of companies and policy numbers:

_____

_____

Name and Address of your doctors during the past year ▼ Sickness or Injury ▼ Date Consulted ▼

_____

_____

_____

These statements are true and complete to the best of my knowledge _____ (Signature of Employee) _____ (Date)

Authorization to Disclose Protected Health Information

Name of Patient/Employee _____ Social Security No. _____

Address _____
No. Street City State Zip

I authorize the physician who signs the Attending Physician's Statement, and all persons and entities affiliated with, part of, or employed by the physician's organized health care arrangement (the "Provider"), to disclose and send the completed Disability Claim Form/Attending Physician's Statement to:

Medical Benefits Mutual Life Insurance Company ("MedBen")
1975 Tamarack Road
P.O. Box 1009
Newark, Ohio 43058-1009
(740) 522-8425 / (800) 423-3151

Further, I authorize the Provider to respond to questions from MedBen and/or its medical consultants related to the health information in the Attending Physician's Statement and the medical condition, history, symptoms, treatment, examination results, prognosis and diagnosis that are related to my claim for disability benefits.

This disclosure is made at my request.

This authorization will be valid for the duration of my claims for disability benefits under the Disability Plan, but not to exceed one year from the date signed.

I understand that I may revoke this authorization at any time by submitting a written revocation to the Provider, except that a revocation will not be effective to the extent that the Provider has already taken action in reliance on this authorization.

I understand that I can obtain a copy of this authorization from the Provider and/or MedBen if I can request one in writing.

Medical treatment is not conditioned on the execution of this authorization. However, no claim for disability benefits under the Disability Plan will be considered unless the Attending Physician's Statement is submitted to MedBen and no claim for disability benefits will be paid if MedBen determines that it does not have sufficient information to determine whether disability benefits are payable.

I understand that the Provider cannot limit or control the subsequent use, reproduction, or dissemination of the information disclosed pursuant to this authorization.

A photocopy of this authorization is as valid as the original.

Date _____ Signature _____

DISABILITY CLAIM FORM

ATTENDING PHYSICIAN'S STATEMENT

1. History

(a) When did symptoms first appear or accident happen? ..... Mo. _____ Day _____ Year _____

(b) Date patient ceased work because of disability ..... Mo. _____ Day _____ Year _____

(c) Has Patient ever had same or similar condition? ..... ☐ Yes ☐ No If "Yes", state when and describe

_____

(d) Is condition due to injury or sickness arising out of patient's employment? ..... ☐ Yes ☐ No ☐ Unknown

(e) Names and addresses of other treating physicians _____

_____

_____

2. Diagnosis

(a) Diagnosis (including any complications) _____

_____

(b) Subjective symptoms _____

_____

(c) Objective findings (including current X-rays, EKGs, Laboratory Data and any clinical findings) _____

_____

3. Dates of Treatment

(a) Date of first visit ..... Mo. _____ Day _____ Year _____

(b) Date patient ceased work because of disability ..... Mo. _____ Day _____ Year _____

(c) Frequency ..... ☐ Weekly ☐ Monthly ☐ Other (Specify) _____

4. Nature of Treatment (including surgery and medications prescribed, if any)

_____

5. Progress

(a) Has patient ..... ☐ Recovered? ☐ Improved? ☐ Unchanged? ☐ Regressed?

(b) Is patient ..... ☐ Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confined?

(c) Has patient been hospital confined? ..... ☐ Yes ☐ No If "Yes", give Name and Address of Hospital _____

_____ Confined from _____ through _____

6. Cardiac (If Applicable)

(a) Functional capacity ..... ☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation)

(American Heart Assoc. classes) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)

(b) Blood Pressure (last visit) ..... Systolic _____ Diastolic _____

7. Prognosis

	Patient's Job		Any Other Work	
(a) Is patient now totally disabled?	☐ Yes	☐ No	☐ Yes	☐ No
(b) What duties of patient's job is he/she incapable of performing? _____				
(c) Do you expect a fundamental or marked change in the future?	☐ Yes	☐ No	☐ Yes	☐ No
(d) If "Yes", when will/or did patient recover sufficiently to perform duties?	☐ 1 mo. ☐ 3-6 mo.	☐ 1-3 mo. ☐ Never	☐ 1 mo. ☐ 3-6 mo.	☐ 1-3 mo. ☐ Never

Remarks _____

8. Rehabilitation

(a) Is patient a suitable candidate for further rehabilitation services? ..... ☐ Yes ☐ No
(i.e., cardiopulmonary program, speech therapy, etc.)

(b) Can present job be modified to allow for handling with impairment? ..... ☐ Yes ☐ No

	Patient's Job		Any Other Work	
(c) When could trial employment commence?	_____/_____/_____	☐ Full-time ☐ Part-time	_____/_____/_____	☐ Full-time ☐ Part-time
	_____/_____/_____		_____/_____/_____	

(d) Would vocational counseling and/or retraining be recommended? ..... ☐ Yes ☐ No

PRINT Physician's Name Degree Specialty Telephone

Street Address City State or Province Zip

Date _____ Signature _____

Tax Identification Number