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Group Disability Plan Claim Form

(please print in ink or type)
Note: Every item must be completed before claim can be processed!

Employer Section

Employee Name: _____ SSN: _____ DOB: _____

On Form W-4: How many withholding allowances claimed: _____ ❍ Single ❍ Married

Date the employee was last active at work: _____ Resumed work: _____

Has employment been terminated? ❍ Yes ❍ No

Is this disability due in any way to the employee's occupation? ❍ Yes ❍ No

Is this disability covered by Worker's Compensation? ❍ Yes ❍ No

_____ _____
Signature of Employer Representative Date

_____ _____
Name of Employer Representative Telephone Number

_____ _____
Employer Name Group Number

Physician Section

Disability a result of: ❍ Illness Date of First Symptom: _____
❍ Injury Date of Accident: _____
❍ Pregnancy Date of LMP: _____

Date(s): First consulted you for this condition _____
Employee able to return to work _____
Total Disability _____ to _____
Partial Disability _____ to _____

Has Employee ever had same or similar symptoms? ❍ Yes ❍ No

Reason for Disability/Condition Diagnosed:

Restrictions:

_____ _____ _____
Signature of Attending Physician Degree Date

_____ _____
Name of Attending Physician Telephone Number

_____
Office Name of Attending Physician

_____ _____
Street Address City, State, Zip Code