



SHORT TERM DISABILITY CLAIM FORM

INSTRUCTIONS:

1. Have your Employer complete the "Employer Statement."
2. Complete the "Employee Statement" in full.
3. Have your Physician complete the "Attending Physician's Statement" on reverse side.
4. TYPE or PRINT so information is legible.
5. IMPORTANT: To assure timely payment of Short Term Disability benefits, this form must be FULLY COMPLETED and submitted IMMEDIATELY following any injury, illness, or medical treatment that results in loss of work due to disability.

Check if your address has changed since your last enrollment form was completed.

EMPLOYER STATEMENT

SICK LEAVE MUST BE EXHAUSTED BEFORE DISABILITY BENEFITS BEGIN (Plan provides limited exceptions)

1. Employee name: _____
2. Employee SSN: _____
3. Date employee last worked: _____
4. Date employee returned, or is *expected* to return, to work: _____
5. Last date for which pay was / will be received: _____
(Use last date of *any* paid hours: worked, vacation, sick leave, etc)
6. Has employee been terminated? Yes No
7. Regularly scheduled gross weekly base wages: _____
8. Work day schedule: M T W Th F Sa Su
(Mark employees regularly scheduled work days)
9. Wages based on how many hours per week? _____
(Number of regular hours)
10. If ordered by employee's physician, is light duty available? Yes No

EMPLOYER NAME: _____ TAXPAYER ID NUMBER: _____
 EMPLOYER ADDRESS: _____ PHONE NUMBER: _____
 SIGNATURE: _____ TITLE: _____ DATE SIGNED: _____
(Authorized employer representative)

EMPLOYEE STATEMENT

I HEREBY APPLY FOR BENEFITS ON ACCOUNT OF DISABILITY

1. Your name: _____
2. Your SSN: _____
3. Your address: _____
(Street address)
4. Date of birth: _____
5. Phone number: _____
(City, State, Zip)
6. Last date worked before disability: _____
7. Date you were first disabled: _____
8. Date returned to work after disability: _____
9. Date you *expect* to return to work: _____
(If not already returned to work)
10. Give medical cause of disability: _____
11. Is the disabling condition caused by your occupation? Yes No If yes, have you filed a Workers' Compensation claim? Yes No
12. Disability is the result of: Illness Pregnancy Accidental Injury (complete 13 below) Other : _____
(Please explain)
13. Provide details of accident or injury. Date of accident or injury: _____ Time of accident or injury: _____ AM / PM
 Where did accident or injury occur? _____
 How did accident or injury occur? _____
14. If hospitalized, name of hospital: _____ Phone Number: _____
 Date admitted: _____ Time: _____ Date discharged: _____ Time: _____
15. Are you eligible for or receiving any state or other disability income? Yes No If yes, please attach a copy of your most recent benefit statement.
16. Do you have group health coverage? Yes No If yes, with whom? _____

EMPLOYEE CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I certify that the above information is true and correct. I authorize all providers of medical care and my employer to furnish the National IAM Benefit Trust Fund or its legal representative with any information necessary to process this claim, including medical and/or employment information. This authorization shall remain valid until the claim has been fully processed or discharged, including any procedures for review or investigation of the claim after payment. I know that I have a right to receive a copy of this authorization upon request. I agree that a photocopy shall be as valid as the original.

EMPLOYEE SIGNATURE: _____ DATE SIGNED: _____

SHORT TERM DISABILITY CLAIM FORM

ATTENDING PHYSICIAN'S STATEMENT

PLEASE TYPE OR PRINT LEGIBLY

PATIENT NAME: _____ DATE OF BIRTH: _____

1. Diagnosis and concurrent conditions: _____

2. Is condition the result of patient's employment? Yes No If yes, has a workers' compensation claim been filed? Yes No

3. Is condition due to pregnancy? Yes No If yes, approximate date pregnancy commenced: _____

Note - Disability certification that exceeds 6 weeks after normal delivery or 8 weeks after cesarean section will require written explanation from attending physician.

4. Is condition due to accidental injury? Yes No If yes, please provide accident date: _____

5. Date symptoms first appeared: _____ 6. Date patient first consulted you for this condition: _____

7. Date of patient's most recent visit in your office: _____ 8. Date of next scheduled visit: _____

9. Additional dates of service for this condition: _____

10. Was patient referred to your office? Yes No If yes, by whom? _____

11. Has patient ever had same or similar condition? Yes No If yes, when? _____

12. Was testing ordered to confirm diagnosis or disability status? Yes No Please explain: _____

13. Is patient still under your care for this condition? Yes No If no, date released from your care: _____

14. Did you refer patient to another physician? Yes No If yes, when and to whom? _____

15. Was there any period of time when this patient was **continuously totally disabled** and unable to perform normal work duties? Yes No If yes:

Please specify dates of total disability. From: _____ To: _____

16. Was the patient hospitalized as a result of this disability? Yes No If yes: Outpatient hospitalization Inpatient admission

Please specify hospitalization dates. From: _____ To: _____

17. Has patient been released to return to work? Yes No If yes, date released to return to work: _____

18. If not released, please **estimate** date patient will be released to return to work (can be extended later if necessary): _____

19. Does the patient have other health coverage? Yes No If yes, please identify: _____

PHYSICIAN NAME / DEGREE: _____

ADDRESS: _____
(Street address)

(City / State / Zip)

SPECIALTY: _____

PHONE NUMBER: _____ FAX NUMBER: _____

I certify the information provided in this Attending Physician's Statement is true and correct, including any certification of total disability as indicated above.

PHYSICIAN SIGNATURE: _____ DATE SIGNED: _____

ADDITIONAL REMARKS: _____

