Short-Term Disability Employee Request

Complete this form for the first seven days of your disability period.
 Ask your physician to complete the Attending Physician's Statement on the reverse side.
 Employee

1.	Employee Information	Social Security Number	Name					
2.	Claim Information	Is your absence work related? No Yes Nature of illness or injury for which c	If claim related to an accident? No Yes If "Yes", date laim is being made. If injury, please describe how, when an			□ pm		
3.	Federal & State Income Tax Withholding	If eligible for short-term disability benefits, Federal and State income tax will be withheld per W-4 form on file.						
4.	Release	and any independent claim address organization with whom my E heath care advice, treatment or AIDS/ARC/HIV). This informs for the term of the policy or compared to the policy or compared to the term of the policy or compared to the policy or	ized to provide my Employer and my Health Fund Office, or one of its affiliated companies, indent claim administrators and consulting health professionals and utilization review the whom my Employer and my Health Fund Office has contracted, information concerning ce, treatment or supplies provided the patient (including that relating to mental illness, and /or V). This information will be used to evaluate claims for benefits. This authorization is valid the policy or contract under which a claim has been submitted. I know that I have a right to of this authorization upon request and agree that a photographic copy of this authorization is as ginal.					
		Employee's Signature		Date				

Plan Summary – Terms and definitions of the plan will determine actual eligibility.

To qualify for a benefit payment because of a non-occupational illness, employee must be confined in a hospital on an in-patient basis for a portion of the first seven days of the disability period or have surgery or other procedure on an outpatient basis for which a general anesthetic is required.

To qualify for a benefit payment because of a non-occupational injury, employee must be seen and treated by a physician or surgeon for the injury.

Claim forms must be submitted within ninety (90) days after the end of the initial seven (7) consecutive days of the disability for which benefit payment is being requested.

Attending Physician's Statement

Employee Information

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The patient is responsible for completion of this form without any expense to the	Social Secu
Company. The Employer or the Health Fund Office may request additional statements	
as necessary	

Name
Social Security Number

Patient's name				Patient's Birthdate					
Date of Illness (first symptom) or injury (accident) or pregnancy (LMP)			Date first seen and troyou for this condition		If patient has had similar illness or injury, give dates		ijury,	If an emergency check here	
Date patient able to return to work			Date of total disability		Date of partial disability				
				From	Throug	gh	From	Thro	ough
Name of referring physician						For serviced re	serviced related to hospitalization give hospitalization da		
						Admitted	Disch	arged	
Name & a	address o	of facility where servi	ices rendered (if other than l	home or office)					
Diagnosis 1.	s or natu	re of illness or injury	(please indicate primary an	d secondary)					
2.									
3.									
4.									
Procedur	res, Med	lical Services, Suppl	ied Furnished						
Date of S		Place of Service*	Description of Service				Type of Servi	ice =	Diagnosis Code ==
									10.1
Physician's Name & Address (include zip code)					be used for 10 You are requi to furnish you number.	Enter the taxpayer identifying number to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number. Telephone Number			
Physician's Signature					Date				
*Place of S 1 - (IH) 2 - (OH) 3 - (O) 4 - (H) 5 - 6 - 7 - (NH)	 Inpati Outpa Office Patien Day C Night 	ent Hospital tient Hospital	9 Ambular 0 - (OL) - Other Lo A - (IL) - Indepen- B Other M C - (RTC) - Residen		1 – M 2 – Su 2 – Co 4 – Di 5 – Di 6 – Ra	e of Service Codes: edical Care irgery onsultation iagnostic X-Ray iagnostic Laborator; adiation Therapy testhesia	8 – Assistance at 9 – Other Medic: 0 – Blood or Pac A – Used DME y M – Alternate Pa Y – Second Opir Z – Third Opinic	al Service ked Red Co syment for nion on Ele	Maintenance Dialysis ctive Surgery