



**HEALTH INSURANCE CLAIM—GROUP OR INDIVIDUAL—DISABILITY INCOME**

**PART A TO BE COMPLETED BY PATIENT (INSURED)**

PATIENT'S NAME AND ADDRESS	DATE OF BIRTH
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Physician to release any information acquired in the course of the examination of my treatment.	SIGNED (PATIENT) _____ DATE _____

**PART B ATTENDING PHYSICIAN'S STATEMENT**

DIAGNOSIS AND CONCURRENT CONDITIONS	
IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? <input type="checkbox"/> Yes <input type="checkbox"/> No	PREGNANCY? <input type="checkbox"/> Yes <input type="checkbox"/> No
DATES OF SERVICES (IF PREVIOUS FORM SUBMITTED TO THIS CARRIER, YOU NEED SHOW ONLY DATES SINCE LAST REPORT)	
DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED	DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION
PATIENT EVER HAD SAME OR SIMILAR CONDITION? IF "YES", WHEN AND DESCRIBE <input type="checkbox"/> Yes <input type="checkbox"/> No	PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? <input type="checkbox"/> Yes <input type="checkbox"/> No
PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK) FROM _____ THRU _____	
PATIENT WAS HOUSE CONFINED FROM _____ THRU _____	IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK
DOES PATIENT HAVE OTHER HEALTH COVERAGE? IF "YES", PLEASE IDENTIFY <input type="checkbox"/> Yes <input type="checkbox"/> No	

DATE	PHYSICIAN'S NAME (PRINT)	SIGNATURE	DEGREE	TELEPHONE
STREET ADDRESS	CITY OR TOWN	STATE OR PROVINCE	ZIP CODE	

**TO BE COMPLETED BY EMPLOYER**

NAME OF EMPLOYEE	
DATE EMPLOYEE FIRST UNABLE TO WORK	DATE
DATE RETURNED TO PART-TIME WORK	DATE
DATE RETURNED TO FULL-TIME WORK	DATE
IF STILL OFF WORK, DATE YOU EXPECT EMPLOYEE TO RETURN	DATE

EMPLOYER'S NAME	EMPLOYER'S ADDRESS	BY	TITLE	DATE
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