



# Claim for Short Term Disability Income Benefits

(See reverse side for instructions)

## EMPLOYEE INFORMATION

1. Your Social Security Number

2. Your Last Name  First Name

3. Your Mailing Address   
STREET  
  
CITY  STATE  ZIP CODE

4. Clock / Badge Number  5. Plant Division / Location \_\_\_\_\_

6. Occupation \_\_\_\_\_

7. Your daytime telephone number           8. Date of birth   
Mo. Day Year

9. Date of accident or beginning of illness      10. Last date of work   
Mo. Day Year

11. Description of accident or illness \_\_\_\_\_

12. If accident, did it occur:  In an Automobile?  While at Work?  Other \_\_\_\_\_

13. Have you, or will you file for Workers' Compensation Benefits?  Yes  No

14. Have you returned to work? If yes, date   
Mo. Day Year

15. Are you covered under another group insurance or government plan or automobile mandatory no-fault coverage which will also cover any of the disability loss of this claim?  Yes  No  
 If yes, give policy number, name and address of Insurance company.

<small>POLICY NUMBER</small>	<small>NAME AND ADDRESS</small>

## AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any dentist, physician, hospital, pharmacy, insurance company or organization to release any information regarding the medical, dental, mental treatment or disability benefits payable for this claim to the plan administrator or its authorized agent for the purpose of validating and determining benefits payable in connection with this claim. I understand that this authorization or a photostat copy of the original shall be valid for one year from date of signature. I understand that data may be extracted and transmitted to the plan administrator for statistical audit and verification purposes. I also understand that I may request a copy of this authorization.

EMPLOYEE'S SIGNATURE

DATE



## PHYSICIAN - COMPLETE THIS SECTION

1. Patient's Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

2. Diagnosis: \_\_\_\_\_

3. Is this work related?  Yes  No

4. Describe current subjective symptoms: \_\_\_\_\_

5. What are your objective findings? \_\_\_\_\_

6. Please show dates of treatment: \_\_\_\_\_

Date of surgery: \_\_\_\_\_ Dates of hospitalization: \_\_\_\_\_

LMP: \_\_\_\_\_ Date/Type of Delivery: \_\_\_\_\_

7. What is current prognosis? \_\_\_\_\_

8. What limitations prevent patient from returning to work? \_\_\_\_\_

9. Because of these limitations, patient was totally disabled and prevented from performing all duties of his/her occupation:

From 

Mo.	Day	Year		

 Through 

Mo.	Day	Year		

10. If still unable to work, when should patient be able to return to work?

Mo.	Day	Year		

Remarks: \_\_\_\_\_

DATE	PHYSICIAN NAME (Please print)	DEGREE	SIGNATURE
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TAX I.D. NUMBER / SOCIAL SECURITY #	TELEPHONE NUMBER (      )
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ADDRESS \_\_\_\_\_

## INSTRUCTIONS FOR FILING A CLAIM

### TO THE EMPLOYEE:

- A. Complete the Employee Information and Authorization to Release Information of the form.
- B. Have the Physician fill out the Physician section.
- C. If you have any questions about a Disability claim, call our Disability Unit at: 800-985-3810 Toll Free anywhere in the U.S.
- D. DO NOT use this form for Medical Expenses.
- E. DO NOT use the Medical Form for Disability claims.
- F. Return the FULLY completed form to:

Liberty Life Assurance Company of Boston  
Group Markets Disability Claims  
P.O. Box 7211  
London, KY 40742-7211  
Fax: 603-422-7905

Any person who knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.