



Disability Claim Form

INSTRUCTIONS:

On this page: fill in name, address, ID#, birth date, tel. Number and your employer's name and address. In the "Disability Information" section complete all requested information. Sign and date the "Employee Certification" section. **On page 2:** have your doctor complete the "Doctor's Statement".

Submit Completed form to: Significa Benefit Services, Inc.
 Fax (717) 581-8379 P. O. Box 7777, Lancaster, Pennsylvania 17604-7777

COMPLETE FOR DISABILITY CLAIM - PLEASE PRINT

Employee Name: _____
 Home Address: _____

Street City State Zip

Member ID #: _____ - _____ - _____ Date of Birth: ____/____/____ Daytime Telephone: (____) ____ - _____
 Mo Day Year

Employer's Name and Address: _____

DISABILITY INFORMATION

1) Occupation (List duties at time of disability)			
2) Date of accident or date sickness began: _____ Month/Day/Year	3) Date you first were unable to work: _____ Month/Day/Year	4) Date you returned to work on a part-time basis: _____ Month/Day/Year	5) Date you returned to work on a full time basis: _____ Month/Day/Year
6) Is your accident or illness job related: <input type="checkbox"/> Yes <input type="checkbox"/> No		7) If question 6 is "Yes" explain: Have you or are you going to file a Worker's Comp. Claim? <input type="checkbox"/> Yes <input type="checkbox"/> No	
8) Describe how and where the accident occurred or describe the nature of your illness:			
9) Date first treated for your illness or injury: _____ Month/Day/Year		10) Treated by: Hospital: _____ Name Street City State Zip Doctor: _____ Name Street City State Zip	
11) Have you ever had the same or similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No		12) If question 11 is "Yes" - Treated by: (Attach additional information if necessary) Hospital: _____ Name Street City State Zip Doctor: _____ Name Street City State Zip	

EMPLOYEE CERTIFICATION AND AUTHORIZATION

I authorize release of any information about this claim and certify that the information is complete and correct. I understand if I knowingly and with intent to defraud you or any person, file a statement of claim containing any materially false information, or conceal for the purpose of misleading information concerning any fact material thereto. ***I commit a fraudulent insurance act, which is a crime and is subject to criminal and civil penalties.***

Employee Signature: _____ Date: _____

OVER

DOCTOR'S STATEMENT (Attach Medical Summaries or Records to help identify problem causing disability.)

1. Date symptoms first appeared or accident happened: _____ / _____ / _____
Mo Day Year
2. Date patient stopped work due to disability: _____ / _____ / _____
Mo Day Year
3. Has patient ever had similar conditions? Yes No If "yes", describe: _____
-
4. Is condition work related: Yes No Is it a pregnancy: Yes No
If "yes", due date: _____ / _____ / _____
5. Diagnosis or Nature of illness or injury: _____
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- (If Diagnosis Code used is other than ICDA* then give name)
6. Objective Findings (including current x-rays, EKG's, Laboratory data and any clinical findings.) _____
-
7. Date of first visit: _____ / _____ / _____ Date of last visit _____ / _____ / _____ Frequency: Weekly Monthly Other _____
8. Course of Treatment - Type and Frequency. If on Medication, list type, dosage and frequency: _____
-
9. Describe physical limitations and how they prevent employment. If progressive, describe progression in detail and last specific changes causing inability to work: _____
10. Has patient: Recovered Improved Unchanged Retrogressed
11. Is Patient: Hospital Confined Bed Confined House Confined Ambulatory
12. Patient was/will be continuously disabled (unable to work) - (dates) from: _____ / _____ / _____ to: _____ / _____ / _____
13. Patient was/will be partially disabled - (dates) from: _____ / _____ / _____ to: _____ / _____ / _____
14. Is Patient still under your care for condition? Yes No If still disabled, date to return to work: _____ / _____ / _____

If previous form was submitted, show dates and service since last report. Report all dates of services starting with the first visit to last visit.

Date of Services	Place of Services	Description of Surgical or Medical Services Rendered	Procedure Code

Codes: (if other than Current Procedural Terminology, give name) O=Doctor's Office IH=Inpatient Hospital NH=Nursing Home
H=Patient's Home OH=Outpatient Hospital OL=Other Location *ICDA-Inter. Classification of Diseases

_____ Date Physician's Name (Print or Type)

_____ Date Physician's Signature

_____ Address

_____ Federal Tax ID Number (required) Telephone Number

THE INFORMATION DISCLOSED ON THIS FORM IS PROTECTED HEALTH INFORMATION WHICH IS PRIVILEGED AND CONFIDENTIAL. THIS INFORMATION WILL NOT BE USED OR DISCLOSED EXCEPT AS PERMITTED OR REQUIRED BY LAW.