



# Disability Claim Form

**INSTRUCTIONS:**

**On this page:** fill in name, address, SS#, 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".

**After it is completed, mail 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: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 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: \_\_\_\_\_  
\_\_\_\_\_
- (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.**