50 E. 91st Street, Suite 305
Indianapolis, IN 46240
800-873-2022 or 317-816-5155
Fax: 317-818-7900

SHORT TERM DISABILITY INCOME CLAIM FORM

INSTRUCTIONS TO EMPLOYEE

1. Statements should be completed as follows: Part A is to be completed by the Employee. Part B is to be completed by the employer. Part C is to be completed by the attending physician.
2. To avoid delay in processing, please be sure that all answers are complete.
3. The employer should mail the completed form to the above address.

PART A EMPLOYEE'S STATEMENT

Company Name _____ Occupation _____

Employee Name _____ Date of Birth / /

Social Security Number _____ Home Telephone ( )

Address of Employee

City *State* *Zip Code*

Date accident occurred or illness began:

Date: / / Hour *AM* *PM*

Describe injuries received or nature of illness

If an accident, describe where and how the accident occurred:

Name(s) of attending physician(s)

If confined in hospital, give name and address of hospital:

Hospital Admission Date / / Time: *AM* *PM* Discharge Date: / /

Date totally disabled by this injury or illness and were totally unable to work Date: / /

If presently working, give date that you returned to work Date: / /

AUTHORIZATION

The above statements are true and complete to the best of my knowledge and belief and I hereby authorize any hospital or physician who has treated me or other person who has attended me or examined me or any company or government agency to furnish Southeastern Indiana Health Organization (SIHO), or their representatives, any and all information with respect to any illness, injury, medical history, consultations prescriptions, treatments or benefits and copies of all applicable records. A photostatic copy of this form will be as valid as the original.

Signature of Employee Date: / /

SHORT TERM DISABILITY CLAIM FORM

PART B EMPLOYER'S STATEMENT

Employee Department _____ Plan No. _____

Eligibility Date / / _____ Effective Date / /

Has Employee requested a claim for Worker's Compensation? ☐ Yes ☐ No

Is Employee entitiled to Worker's Compensation ☐ Yes ☐ No

Employee last worked / / Weekly Wages Weekly Disability Income

Percentage of Contribution toward disability Premium _____ paid by Employer

_____ paid by Employee

100%

Has Employee returned to work? ☐ Yes ☐ No Disability Payments Begin / /

Date: / / Employer

Mailing Address

Street *City* *State* *Zip Code*

By (Authorized Employer Representative)

Name Title

PART C ATTENDING PHYSICIAN'S STATEMENT

1. Diagnosis and concurrent conditions.
   If diagnosis code other than ICD-9 used, give narrative:
2. Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No
   Is condition due to pregnancy? ☐ Yes ☐ No
4. Symptoms first appeared or accident occurred Date: / /
5. Patient first consulted you for this condition Date: / /
6. Patient ever had same or similar condition? ☐ Yes ☐ No
7. Patient still under your care for this condition? ☐ Yes ☐ No
8. Patient was continuously totally disabled (unable to work) From / / thru / /
9. Patient was partially disabled From / / thru / /

   Restrictions:
10. If still disabled, date patient should be able to return to work Date: / /
11. Next Appointment Date: / / Remarks:

Date: / / Physician's Name (Print) Physician Type

Physician's Signature

Street Address City State Zip

Telephone Fax Number

Individual Practitioner's SS# Employer ID