



# GROUP DISABILITY CLAIM FORM

Instructions: All questions must be answered. Please print. Return completed claim form to employer at once.

EMPLOYEE'S STATEMENT OF CLAIM FOR GROUP HEALTH BENEFITS					
1. EMPLOYEE NAME		SOCIAL SECURITY NO.	DATE OF BIRTH	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED
2. EMPLOYEE'S ADDRESS			CITY	STATE	ZIP CODE
3. DATE TOTAL DISABILITY COMMENCED	DATE LAST WORKED	DATE TOTAL DISABILITY CEASED	EMPLOYEE'S PHONE NUMBER		
4. IS DISABILITY DUE TO AN ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF ACCIDENT	IF 'YES', WHERE DID ACCIDENT OCCUR			
DESCRIBE ACCIDENT?					
5. IS THIS ACCIDENT THE RESULT OF A WORK RELATED ILLNESS OR INJURY? <input type="checkbox"/> YES--PLEASE PROVIDE DETAILS ON <input type="checkbox"/> NO SEPARATE SHEET			IF 'YES', ON WHAT DATE DID YOU FILE YOUR WORKER'S COMPENSATION CLAIM?		
6. HAVE YOU APPLIED FOR OR ARE YOU RECEIVING BENEFITS UNDER ANY OF THE FOLLOWING SOURCES:					
<input type="checkbox"/> SALARY CONTINUATION PLAN		<input type="checkbox"/> UNEMPLOYMENT INSURANCE			
<input type="checkbox"/> SOCIAL SECURITY DISABILITY		<input type="checkbox"/> OTHER (PLEASE SPECIFY)			

I certify that the above is true and correct. I hereby authorize all doctors, hospitals, or other institutions rendering care and treatment to furnish Allied Benefit Systems, Inc. with full information regarding treatment rendered (Including copies of their records.)

Signature \_\_\_\_\_ Date \_\_\_\_\_

PARTICIPATING EMPLOYER'S STATEMENT			
1. EMPLOYEE'S NAME		SOCIAL SECURITY NUMBER	DATE EMPLOYED
2. EFFECTIVE DATE OF INSURANCE		OCCUPATION	BRIEF JOB DESCRIPTION
3. WEEKLY WAGES	WEEKLY BENEFIT	DATE EMPLOYEE LAST WORKED	DATE DISABILITY COMMENCED
4. DATE DISABILITY CEASED	HAS EMPLOYEE RETURNED TO WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF 'YES', ON WHAT DATE?
5. DO YOU HAVE CLAIM INFORMATION RE: WORKER'S COMPENSATION OR OTHER DISABILITY INCOME BENEFITS THAT WOULD AFFECT THIS CLAIM? <input type="checkbox"/> YES--PLEASE EXPLAIN <input type="checkbox"/> NO			
6. IS THIS A RECURRENCE WITHIN 2 WEEKS OF A PREVIOUS DISABILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			
7. PARTICIPATING EMPLOYER'S NAME			EMPLOYER'S GROUP NUMBER.
8. EMPLOYER'S ADDRESS			
9. SIGNATURE OF EMPLOYER'S REPRESENTATIVE		TITLE	DATE

