Notice of Claim for Short Term Disability Benefits

AS REQUIRED BY LAW, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERE TO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND MAY ALSO BE SUBJECT TO CIVIL PENALTIES FOR EACH SUCH VIOLATION.

EMPLOYEE'S STATEMENT (ALL QUESTIONS MUST BE ANSWERED TO AVOID DELAY)

Name of Employee

Male ☐ Female ☐

Employee's Social Security or I.R.S. Number - -

Employee's Address: Street & No. City State Zip

Telephone No. ( ) -

Date of Birth MO/DAY/YEAR

Date Accident or Sickness Began

Date Last Worked

Date First Treated

Nature of Sickness or Injury

If Injured, How and Where Did Accident Happen?

Did Accident Happen at Work? ☐ Yes ☐ No

Name and Address of Physician First Consulted for this Condition:

Name and Address of Family Physician

Name and Address of Hospital, if Confined

Dates of Inpatient Confinement
IN OUT

Are You Entitled to Benefits from any of the Following for this Disability? ☐ Association Membership
☐ Worker's Compensation ☐ Salary Continuance ☐ No Fault ☐ Social Security ☐ Any Government Agency
☐ Public or Private Retirement Benefit ☐ Other ______________________________ ☐ None
If "Yes" List Policy Number, Name, Address and Phone # of Insurance Co. or Organization Providing Such Benefits or Services:

Policy No. Name and Address Phone No.

Policy No. Name and Address Phone No.

I CERTIFY THAT THE STATEMENTS IN THIS SECTION ARE TRUE AND COMPLETE:

Signature of Employee Date

EMPLOYER'S STATEMENT (ALL QUESTIONS MUST BE ANSWERED TO AVOID DELAY)

Name of Employee

Occupation

Is Disability Due to Employment? ☐ Yes ☐ No

Number of Hours Worked Per Week:

Salary $ ☐ Per Week ☐ Per Month

Date Employed

Date Insured

Date Last Worked

Reason For Stopping Work
☐ Dismissed ☐ Leave of Absence ☐ Disability
☐ Resigned ☐ Retired ☐ Layoff

Date Returned to Work (or Expected)
☐ Full Time ☐ Part-Time
MO/DAY/YR | MO/DAY/YR

If Part-Time, Hours Per:
☐ Day ☐ Week

Date Employment Term'd (or Expected):
MO/DAY/YEAR

Premium Contribution %
Employer _100_% Employee_%

I CERTIFY THAT THE STATEMENTS IN THIS SECTION ARE TRUE AND CORRECT

Signature Print Name Title Date

Telephone Number Fax Number Mailing Address

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SEND COMPLETED FORMS TO:	**Disability Insurance Specialists**	**PO BOX 29**	**BLOOMFIELD, CT 06002**
	FAX #: (860) 769-6986	**PHONE #:**	**1-800-722-9680**

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