



Claim for Short Term Disability Income Benefits

(See reverse side for instructions)

EMPLOYEE INFORMATION

1. Your Social Security Number

2. Your Last Name

First Name

3. Your Mailing Address

STREET

CITY

STATE

ZIP CODE

4. Clock / Badge Number

5. Plant Division / Location

6. Occupation

7. Your daytime telephone number

8. Date of birth

Mo. Day Year

9. Date of accident or beginning of illness

Mo. Day Year

10. Last date of work

Mo. Day Year

11. Description of accident or illness

12. If accident, did it occur: In an Automobile? While at Work? Other

13. Have you, or will you file for Workers' Compensation Benefits? Yes No

14. Have you returned to work? If yes, date

Mo. Day Year

15. Are you covered under another group insurance or government plan or automobile mandatory no-fault coverage which will also cover any of the disability loss of this claim? Yes No

If yes, give policy number, name and address of Insurance company.

POLICY NUMBER

NAME AND ADDRESS

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any dentist, physician, hospital, pharmacy, insurance company or organization to release any information regarding the medical, dental, mental treatment or disability benefits payable for this claim to the plan administrator or its authorized agent for the purpose of validating and determining benefits payable in connection with this claim. I understand that this authorization or a photostat copy of the original shall be valid for one year from date of signature. I understand that data may be extracted and transmitted to the plan administrator for statistical audit and verification purposes. I also understand that I may request a copy of this authorization.

EMPLOYEE'S SIGNATURE

DATE

PHYSICIAN - COMPLETE THIS SECTION

1. Patient's Name: _____ Social Security #: _____

2. Diagnosis: _____

3. Is this work related? Yes No

4. Describe current subjective symptoms: _____

5. What are your objective findings? _____

6. Please show dates of treatment: _____

Date of surgery: _____ Dates of hospitalization: _____

LMP: _____ Date/Type of Delivery: _____

7. What is current prognosis? _____

8. What limitations prevent patient from returning to work? _____

9. Because of these limitations, patient was totally disabled and prevented from performing all duties of his/her occupation:

From

Mo.	Day	Year		

 Through

Mo.	Day	Year		

10. If still unable to work, when should patient be able to return to work?

Mo.	Day	Year		

Remarks: _____

DATE	PHYSICIAN NAME (Please print)	DEGREE	SIGNATURE
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TAX I.D. NUMBER / SOCIAL SECURITY #	TELEPHONE NUMBER ()
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ADDRESS _____

INSTRUCTIONS FOR FILING A CLAIM

TO THE EMPLOYEE:

- A. Complete the Employee Information and Authorization to Release Information of the form.
- B. Have the Physician fill out the Physician section.
- C. If you have any questions about a Disability claim, call our Disability Unit at: **800-985-3810** Toll Free anywhere in the U.S.
- D. **DO NOT** use this form for Medical Expenses.
- E. **DO NOT** use the Medical Form for Disability claims.
- F. Return the **FULLY** completed form to:

Liberty Life Assurance Company of Boston
Group Markets Disability Claims
P.O. Box 7211
London, KY 40742-7211
Fax: 603-422-7905

Any person who knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.