Short Term Disability Claim Form

Mail completed form to:

Northeast Benefits Management, LLC
PO Box 2363, South Burlington, VT 05407-2363
Phone: (802) 865-0239 Fax: (802) 304-1067 or (802) 304-1009
e-mail: info@nbmus.com

Employee's Statement (Please Print)

Full Name (last, first, middle initial	Date of Birth	Social Security #	
Address	City	State	Zip Code
Phone Number	Email Address		
Employer Name	Occupation		
Date last worked due to injury/sickness	Date of onset of condition		
Hospital Confined ___Yes ___No Dates of Confinement:			
Nature of current disability			
Name of treating Physician*	Treating Physicians' Phone number		
Treating Physicians' Address			
Date of first visit for this condition	Date of next visit for this condition		

*Please provide names, addresses, and phone numbers of all treating Physicians.

Did accident/injury occur at work or as a result of an automobile accident?
If auto accident, please provide the claim number and insurance company responsible for the claim:
If you are receiving payments from an insurance company due to an automobile accident, please provide payment amount: Date payments began: Date payments are expected to end:
The above statements are true and complete to the best of my knowledge and belief. I have completed and attached the Authorization to Release of Information. _____ _____ Print Name Date _____ _____ Signature Date

*Processing may be delayed if the claim form is not fully completed.

Authorization for Release of Information

- **I (the undersigned) authorize** any physicians, medical professional, pharmacist or other provider of health care services, hospital, clinic, other medical or medically related facility; insurance or reinsurance company; government agency; department of labor; acquaintance; group policy holder; employer; or policy or benefit plan administrator to release information from the records of:

Claimant/Patient Name: _____
(Last) (First) (Middle Initial)

Date of Birth: _____ Social Security Number: _____

- Information to be released:
  - Data or records regarding my medical history, treatment, prescriptions, consultations (including medical and psychological reports, records, charts, notes, x-rays, films or correspondence, and any medical conditions I may now have or have had- excluding psychotherapy notes)
  - Any information regarding insurance coverage, and
  - Any information, data or recordings regarding my activities (including records relating to my Social Security, Workers' Compensation, Retirement Income, financial, earnings and employment history).

- Information to be released to:

  Northeast Benefits Management, LLC
  PO Box 2363
  South Burlington, VT 05407-2363
  Phone: (802) 865-0239 Fax: (802) 304-1067 or (802) 304-1009

- I understand the information obtained by use of this Authorization will be used to evaluate my claim for disability benefits. The information will only be released to:
  - Other persons or organizations performing business or legal services in connection with my claims(s); or
  - To vendors/consultants providing the claimant with wellness, disability or leave related services as part of an employer sponsored benefit plan
  - To the employer for self-insured disability plans; or
  - As otherwise may be required by law or as I may further authorize.

- I understand the information used or disclosed may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

- I understand that I may revoke this Authorization in writing at any time, except to the extent:
  - The company has taken action in reliance on the Authorization; or
  - The company is using this Authorization in connection with a contestable claim.

  If written revocation is not received, this Authorization will be considered valid for a period of time not to exceed 24 months from the date of my signature below. To initiate revocation of this Authorization, direct all correspondence to the company at the above address.

I further understand that refusal to sign the Authorization may result in the denial of benefits

Print Name: _____ Phone Number: _____

Street Address: _____ City_____ State____ Zip Code_____

Claimant Signature: _____ Date: _____

Nearest relative, legal guardian, or appointed representative to sign only if claimant/patient is a minor, legally incompetent, or deceased. Power of attorney or guardianship must be attached.

Relationship to Claimant of personal/legal representative signing for Claimant/Patient: _____

Print Name: _____ Phone Number: _____

Street Address: _____ City_____ State____ Zip Code_____

Representative Signature: _____ Date: _____

Employer's Statement (Please Print)

Employer Name		Employer Phone Number	
Employer Address	City	State	Zip Code
Employee Name (last, first, middle initial)		Date of Birth	
Date of Hire	Effective Date of Coverage		
Number of hours regularly worked per week	Last Date Worked	Date Expected to Return	
Reason for discontinuing work	Is the Condition work related?		
Has a Worker's Compensation claim been filed?	If so, Date claim was filed		

How was the Employee paid?
__Hourly __ Salary __ Overtime __Bonus __Commissions __Other

Last day of pay period _____	Payroll Frequency _____ (weekly, bi-weekly, semi-monthly, monthly)	# of days in pay period _____

Salary/Wage prior to last date worked*
$_____

__Hourly __Weekly
__Bi-Weekly __Semi-Monthly

Base Pay: $_____ Overtime: $_____

Bonuses $_____ (per week)	Commissions $_____ (per week)	
Date paid through	401(k)403b _____%	Pre-tax medical and other insurance $_____/week

The above statements are true and complete to the best of my knowledge and belief.

_____
Name & Title of person completing this form

_____ _____ _____
Phone Number Fax Number Email

_____ _____
Signature Date

*Please complete the pay log of past pay

Salary Information/Pay log

Employee Name: _____

Employer Name: _____

Please provide the income for the **8 weeks** prior to the date the disability began.

Payroll Frequency: _____ (weekly, bi-weekly, semi-monthly, monthly)

1. Date_____ Days/Hours worked _____ Base Compensation: $_____
   Overtime: $_____ Bonus $_____ Commission $_____
2. Date_____ Days/Hours worked _____ Base Compensation: $_____
   Overtime: $_____ Bonus $_____ Commission $_____
3. Date_____ Days/Hours worked _____ Base Compensation: $_____
   Overtime: $_____ Bonus $_____ Commission $_____
4. Date_____ Days/Hours worked _____ Base Compensation: $_____
   Overtime: $_____ Bonus $_____ Commission $_____
5. Date_____ Days/Hours worked _____ Base Compensation: $_____
   Overtime: $_____ Bonus $_____ Commission $_____
6. Date_____ Days/Hours worked _____ Base Compensation: $_____
   Overtime: $_____ Bonus $_____ Commission $_____
7. Date_____ Days/Hours worked _____ Base Compensation: $_____
   Overtime: $_____ Bonus $_____ Commission $_____
8. Date_____ Days/Hours worked _____ Base Compensation: $_____
   Overtime: $_____ Bonus $_____ Commission $_____

ATTENDING PHYSICIAN'S STATEMENT

Name of Patient: _____ Date of Birth: _____

Employer Name: _____ (must be completed)

1. HISTORY

(a) Date symptoms first appeared or accident happened? _____/_____/_____
(b) Date patient ceased work because of disability? _____/_____/_____
(c) Has patient ever had same or similar condition? Yes ☐ No ☐
If "Yes" state when and describe:

_____

2. DIAGNOSIS (including any complications)

_____

(a) Date of examination _____/_____/_____
(b) Subjective symptoms: _____
(c) Objective findings (including current x-rays, EKG's, Laboratory Data and any clinical findings):

_____

3. DATES OF TREATMENT

First visit _____/_____/_____
Last visit _____/_____/_____
Next visit _____/_____/_____

4. NATURE OF TREATMENT (including surgery and medications prescribed, if any

_____

_____

(a) Was the patient advised to stop working due to this condition at any time? Yes ☐ No ☐
(b) If yes, dates from: _____/_____/_____ to: _____/_____/_____

If Birth of a Child: C-Section Vaginal Circle One

5. PROGRESS

(a) Has patient Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed? ☐
(b) Is patient Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confined? ☐
(c) Has patient been hospital confined? Yes ☐ No ☐ If yes, give Name and Address of Hospital:

_____
_____

Confined from _____ through _____

6. PROGNOSIS ***(This classification is for the purpose of ability to work at current job)***

(a) Is patient now totally disabled? Yes ☐ No ☐
(b) Is patient partially disabled? Yes ☐ No ☐ Must complete (f) if checked yes.
(c) Have you advised the patient to return to work? Yes ☐ No ☐

Questions continued on next page

(d) If yes, please provide return to work date: _____/_____/_____
(e) Full Time ☐ Part Time ☐ If Part Time, number of hours per day _____
(f) What restrictions have you placed on your patient?

_____
_____
_____

7. ADDITIONAL REMARKS/REFERRALS TO ADDITIONAL PROVIDERS

_____
_____
_____
_____

8. ATTACH VISIT NOTES IF ADDITIONAL INFORMATION APPLICABLE

_____ _____ _____
Name (Attending Physician) Print | Name of Practice | Telephone Number

_____ _____
Physician's Signature | Date

_____ _____
Street Address City or Town | T.I.N

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