## **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		Soc	Social Security #		
Address	City			State	Zip Code	
Phone Number	Em	ail Addr	ess			
Employer Name	•		Occup	oation		
Date last worked due to injury/sickness		Date	of onse	t of co	ondition	
Hospital ConfinedYesNo Dates of Confinement:						
Nature of current disability		•				
Name of treating Physician*			7	reatin	g Physicians' P	hone number
Treating Physicians' Address						
Date of first visit for this condition		Date o	f next v	isit foi	this condition	
*Please provide names, addresses, and phone r	number	rs of all t	reating	Physic	ians.	
Did accident/injury occur at work or as a res	sult of	an autoi	nobile	accide	nt?	
If auto accident, please provide the claim no	umber	and insu	ırance (	compa	ny responsible	for the claim:
If you are receiving payments from an insur provide payment amount:	ance c	ompany	due to	an au	tomobile accid	ent, please
Date payments began:	Da	ate payr	nents a	re exp	ected to end:	
The above statements are true and complete attached the Authorization to Release of Information			ny know	/ledge	and belief. I ha	ve completed and
Print Name			D	ate		
Signature			D	ate		<del></del>

<sup>\*</sup>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:	Pho	Phone Number:		
Street Address:	City	State	_ Zip Code	
Claimant Signature:		Date:		
Nearest relative, legal guardian, or incompetent, or deceased. Power	· ·	•		
Relationship to Claimant of person	al/legal representative sign	ing for Claimant/Pa	tient:	
Print Name:	Phon	e Number:		
Street Address:	City	State	_Zip Code	
Representative Signature:		Date:		



# **Employer's Statement (Please Print)**

Employer Name			Employer Phone Number			
Employer Address		Ci	ty		State	Zip Code
Employee Name (last, first, m	iddle initial)			Date	of Birth	
Date of Hire	Effective I	Date of	Coverage			
Number of hours regularly w	orked per week	Last	t Date Worked Date Expected to R			ted to Return
Reason for discontinuing wor	k		Is the Condition	n work	related?	
Has a Worker's Compensation	n claim been filed?		If so, Date	claim	was filed	
How was the Employee paid?Hourly Salary O		sC	ommissions	_Other		
Last day of pay period Payroll Frequency # of days in pay period				y period		
(weekly, bi-weekly, semi-monthly)					<del></del>	
Salary/Wage prior to last date worked*HourlyWeekly \$Semi-Monthly						
Base Pay: \$ Overtime: \$						
Bonuses \$ (per w	eek)		mmissions		(per we	eek)
Date paid through	401(k)403b %		Pre-tax medic	al and /we		irance
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		_	

<sup>\*</sup>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	y, semi-monthly, monthly)
1.	Date Overtime: \$	Days/Hours worked Bonus \$	Base Compensation: \$ Commission \$
	Date Overtime: \$	Days/Hours worked Bonus \$	Base Compensation: \$ Commission \$
3.	Date Overtime: \$	Days/Hours worked Bonus \$	Base Compensation: \$ Commission \$
4.	Date Overtime: \$	Days/Hours worked Bonus \$	Base Compensation: \$ Commission \$
5.	Date Overtime: \$	Days/Hours worked Bonus \$	Base Compensation: \$ Commission \$
6.	Date Overtime: \$	Days/Hours worked Bonus \$	Base Compensation: \$ Commission \$
7.	Date Overtime: \$	Days/Hours worked Bonus \$	Base Compensation: \$ Commission \$
8.	Date Overtime: \$	Days/Hours worked Bonus \$	Base Compensation: \$ Commission \$



ATTENDING PHYSICIAN'S STATEMENT	
Name of Patient: Date of Birth:	
Employer Name:( completed)	must be
1. HISTORY	
<ul> <li>(a) Date symptoms first appeared or accident happened?/</li></ul>	
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 \( \sqrt{\text{No}} \) No \( \sqrt{\text{b}} \) If yes, dates from: \( \sqrt{\text{L}} \sqrt{\text{L}} \sqrt{\text{L}} \) to: \( \sqrt{\text{L}} \sqrt{\text{L}} \sqrt{\text{L}} \)	ı
(a) Has patient Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed? ☐ (b) Is patient Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confice (c) Has patient been hospital confined? Yes ☐ No ☐ If yes, give Name and Address of Ho	
Confined from through	
6. PROGNOSIS (This classification is for the purpose of ability to work at current job)	
<ul> <li>(a) Is patient now totally disabled? Yes □ No □</li> <li>(b) Is patient partially disabled? Yes □ No □ Must complete (f) if checked yes.</li> <li>(c) Have you advised the patient to return to work? Yes □ No □</li> </ul>	



(d) If yes, please provide return to work date: _ (e) Full Time □ Part Time □ If Part Time, nu (f) What restrictions have you placed on your part Time.	mber of hours per day	
7. ADDITIONAL REMARKS/REFERRALS TO ADI	DITIONAL PROVIDERS	
8. ATTACH VISIT NOTES IF ADDITIONAL INFOR	RMATION APPLICABLE	
Name (Attending Physician) Print	Name of Practice	Telephone Number
Street Address City or Town		T.I.N

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