

## 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.



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? <input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Overtime <input type="checkbox"/> Bonus <input type="checkbox"/> Commissions <input type="checkbox"/> 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* \$ _____	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> 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 _____<br>Overtime: \$ _____ | Days/Hours worked _____<br>Bonus \$ _____ | Base Compensation: \$ _____<br>Commission \$ _____ |
| 2. | Date _____<br>Overtime: \$ _____ | Days/Hours worked _____<br>Bonus \$ _____ | Base Compensation: \$ _____<br>Commission \$ _____ |
| 3. | Date _____<br>Overtime: \$ _____ | Days/Hours worked _____<br>Bonus \$ _____ | Base Compensation: \$ _____<br>Commission \$ _____ |
| 4. | Date _____<br>Overtime: \$ _____ | Days/Hours worked _____<br>Bonus \$ _____ | Base Compensation: \$ _____<br>Commission \$ _____ |
| 5. | Date _____<br>Overtime: \$ _____ | Days/Hours worked _____<br>Bonus \$ _____ | Base Compensation: \$ _____<br>Commission \$ _____ |
| 6. | Date _____<br>Overtime: \$ _____ | Days/Hours worked _____<br>Bonus \$ _____ | Base Compensation: \$ _____<br>Commission \$ _____ |
| 7. | Date _____<br>Overtime: \$ _____ | Days/Hours worked _____<br>Bonus \$ _____ | Base Compensation: \$ _____<br>Commission \$ _____ |
| 8. | Date _____<br>Overtime: \$ _____ | Days/Hours worked _____<br>Bonus \$ _____ | Base Compensation: \$ _____<br>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: \_\_\_\_/\_\_\_\_/\_\_\_\_

### 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?

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**7. ADDITIONAL REMARKS/REFERRALS TO ADDITIONAL PROVIDERS**

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**8. ATTACH VISIT NOTES IF ADDITIONAL INFORMATION APPLICABLE**

_____	_____	_____
Name (Attending Physician) Print	Name of Practice	Telephone Number
_____		_____
Street Address City or Town		T.I.N

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