



Weekly Disability Income Claim Form

Diversified Administration Corporation
Attn: Disability Income Claims Dept.
P. O. Box 299
Marlborough, CT 06447
Tele. # 1-888-322-2524 Ext. 537
Fax # 1-860-295-1296

Group Number _____

Name of Employer _____

Part 1 Employer's Statement

- Employee Name: _____ 2. Social Security Number: _____
- Employee's **weekly** wage: _____ 4. Last Day Worked: _____ Returned: _____
- Is the claim one which may be due to a work related injury or occupational disease? Yes No If yes, have you filed a claim with the Worker's Compensation carrier? Yes No
- Was this disability due to an accident? Yes No
- Is the claimant still employed? Yes No If no, date of termination: _____ and reason for termination _____
- Federal Tax Withholding (based on W-4 filing status)** Number of Allowances _____ Married Single

Signature of Official Representative _____ Date _____

IMPORTANT: To prevent overpayments, the Employer must contact the Disability Claims Department on the day that the employee returns to work, even if it is on a part-time basis.

Part 2 Claimant's Statement

- Claimant's name: _____ Birth Date: _____ Phone Number: (____) _____
Mailing Address: _____ City _____ State _____ Zip Code _____
- If claim is due to an accident, brief description of how and where it occurred. _____
Date of Accident: _____
- Are you currently employed with any other employer? Yes No If yes, name, address and phone number of other employer: _____

I hereby certify that the information on this form is complete and accurate to the best of my knowledge. I also agree to reimburse my employer to the extent of any overpayment, which is in excess of the amounts payable under this Disability Income Benefits Plan.

I hereby authorize any person or institution rendering care or any person or organization in possession of insurance or medical or employment information concerning me to furnish full information regarding such care, insurance or employment upon request to Diversified Administration Corporation.

I understand and agree that the information on my claim may be given to the Plan Administrator and its authorized agents, insurance carriers and representatives, by Diversified Administration Corporation for tax purposes, claims handling, underwriting, statistical, audit, verification and other necessary Disability Income Plan operations.

Employee's Signature _____ Date _____

Part 3 Attending Physician's Statement

- Diagnosis {please provide ICD-9 Code(s) and description(s)}: _____
- Date patient first consulted you for this condition: _____ If pregnancy, expected date of delivery: _____
- Was patient hospitalized? Yes No If yes: From: _____ To: _____
- Did the patient have surgery? Yes No If yes, please provide date _____ and Procedure Code(s) and/or description of surgical procedures: _____
- Is the patient still under your care for this condition? Yes No If yes, date of next appointment: _____
- Dates patient was continuously and totally disabled (unable to perform duties at work): From: _____ To: _____
- If still disabled, give date patient should be able to return to work: _____
{Note: If you unable to give a return to work date at this time, please send an update in 30 days with a copy of this form.}

Physician Name _____ Physician Signature _____ Degree _____ Date _____

Street Address _____ City or Town _____ State _____ Zip Code _____

Telephone Number _____ Fax Number _____

IMPORTANT: NO BENEFITS CAN BE PAID UNTIL THIS FORM IS COMPLETED AND RETURNED TO OUR OFFICE