



STATEMENT OF CLAIM FOR DISABILITY BENEFITS

Group name _____

EMPLOYEE SECTION:

Employee's Name: _____ Social Security No. _____

Present Address: _____ City _____ State _____

Phone (_____) _____ Date you were first disabled by this injury or illness _____

If you were in the Hospital as an in-patient, answer the following:

Name & Address of Hospital _____

Date Admitted _____ at a.m./p.m. Date Discharged _____ at a.m./ p.m.

Was an accident involved? _____ Yes _____ No If Yes, answer the following:

When did the accident happen? Date _____ a.m./p.m.

Were you at work when accident happened? _____ Yes _____ No

Give brief description of the accident or sickness: _____

Name of Attending Physician _____ Telephone #_(_____)_____

Address of Attending Physician _____

First Date of treatment by attending physician for this sickness or injury _____

When do you expect to return to work _____

I hereby authorize the Physician to release any information requested with respect to this claim. I certify that the information furnished by me in support of this claim is true and correct. A copy of this document shall be as valid as the original.

EMPLOYEE'S SIGNATURE _____ DATE _____

EMPLOYER SECTION:

Employer: _____ Group Number _____

Employee: Salaried _____ Hourly _____ Full Time _____ Part Time _____ Hourly Rate: _____ Salary Rate: _____

Occupation/Description: _____

Is Workers Compensation being filed? _____ Are Disability Benefits Payable? _____

Last Day Worked: _____ Date Returned to Work: _____ Date Expected to Return to Work: _____

SIGNATURE/TITLE _____ PHONE _____ DATE _____

AULTCARE DISABILITY ADMINISTRATION P.O.BOX 6910 CANTON OH 44706
PHONE: 330-438-6360 OR 800-344-8858 FAX 330-363-2096
www.aultcare.com



ATTENDING PHYSICIAN STATEMENT

Patient's Name _____ Age _____

Nature of sickness or injury with appropriate ICD-9 Code (Describe complications if any): _____

Did the sickness or injury arise out of patient's employment? YES _____ NO _____ If "Yes," explain: _____

Nature of surgery, if any (Describe fully): _____

_____ Date performed _____

Give dates of treatment: Office _____

Hospital - Inpatient _____ Outpatient _____

Is this patient able to return to modified or transitional work? YES _____ NO _____ If Yes, Date: _____

Please explain any restrictions that may apply: _____

Has the patient been totally and continuously disabled (unable to work)? YES _____ NO _____

IF YES, DISABILITY DATES: (MUST BE COMPLETED)

From _____ To _____ Return to work _____ Estimated _____ Actual _____

REMARKS _____

Attending Physician Name (Please Print) _____

Address _____ City _____ State _____

Phone Number _____ Fax Number _____

Attending Physician Signature _____

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