

Disability Claim Form



1231 East Beltline NE, MS 2170, Grand Rapids, MI 49525
 Fax: 616 464-8501

Section 1 - Employee information

Employee last name		First name		Middle initial	Social Security number - -
Street address			City	State	ZIP code
<input type="checkbox"/> Check if new address	Home phone ()	Birth date / /		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
E-mail address		Marital status <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated		Height	Weight
Employer name				Group number	

Section 2 - Disability claim information

Occupation		List the duties of your occupation or job description at the time of your disability.			
Date of accident or date you first noticed symptoms of disability: / /	You have been unable to work because of this disability since what date: / /	<input type="checkbox"/> Yes <input type="checkbox"/> No Have you returned to work? If yes, when? _____ If no, when do you expect to return to work? _____			
Describe in detail how, when and where the accident occurred or describe the nature of your disability and its first symptoms					
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is your accident or illness related to your occupation? If yes, please explain. _____				
<input type="checkbox"/> Yes <input type="checkbox"/> No	Was the injury due to an automobile accident?				
<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you filed a Workers Compensation Claim?				
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you intend to file a Workers Compensation Claim?				
<input type="checkbox"/> Yes <input type="checkbox"/> No	If the injury was due to an accident, have you applied for no-fault benefits? If yes, list the name, address and phone number of the carrier. _____				
When were you first treated for your illness or injury? / /	Hospital name		Hospital address		
Doctor name		Doctor address			
Have you ever had the same or similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospital name		Hospital address		
Doctor name		Doctor address			

Section 3 - Authorization

The above statements are true and complete to the best of your knowledge and belief. Your signature is required for benefit consideration.

Employee signature	Date / /
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Section 4 - To be completed by your employer

Name and address of employer					
<input type="checkbox"/> Yes <input type="checkbox"/> No	Was the injury due to an automobile accident? If yes, what is the date leave of absence or lay-off started? _____			Was coverage terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What was the last day worked? / /	Date paid through: / /	Has employee returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No		Wage: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly \$ _____	
Employer signature			Title	Date / /	