

Disability Claim Form

1231 East Beltline NE • MS2260 • Grand Rapids, MI 49525 • Fax: 616 942-0631



SECTION 1 - EMPLOYEE INFORMATION

Employee Last Name	First Name	Middle Initial	Social Security Number	
Street Address	<input type="checkbox"/> Check if New Address	City	State	Zip Code
Home Phone () -	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Height	Weight	Birth Date / /
Employer Name	Group Number	Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed	<input type="checkbox"/> Separated <input type="checkbox"/> Divorced

SECTION 2 - DISABILITY CLAIM INFORMATION

Occupation	List the duties of your occupation at the time of your disability:			
Date of accident or date you first noticed symptoms of your disability / /	You have been unable to work because of this disability since what date: / /	Have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No	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:				
Is your accident or illness related to your occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:	Was 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 injury was due to an accident, have you applied for no-fault benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list the name, address, and phone number of the carrier:			
When were you first treated for your illness or injury? / /	Hospital name and address:	Doctor name and address:		
Have you ever had the same or a similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide information:	Hospital name and address:	Doctor name and address:		

SECTION 3 - AUTHORIZATION

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

Employee Signature: _____ Date: _____

SECTION 4 - TO BE COMPLETED BY YOUR EMPLOYER

Name and Address of Employer		
At the time of injury or sickness, was employee on leave of absence or lay-off? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, give 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	If yes, date: / /	
Wage: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly \$		
Employer Signature: _____	Date: _____	
Title: _____		