

# MERITAIN HEALTH

## GROUP DISABILITY INCOME CLAIM FORM

Any person who knowingly and with intent to defraud any insurance company or other person files a statement containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

### INSTRUCTIONS FOR FILING A CLAIM

**THIS FORM IS FOR EMPLOYEE DISABILITY INCOME BENEFITS ONLY.  
YOUR CLAIM WILL BE SUBJECT TO DELAY OR RETURN IF THESE INSTRUCTIONS ARE NOT FOLLOWED.**

- TO THE EMPLOYEE:**
- A. Complete the employee section of this form.
  - B. Have the reverse side of the form completed and signed by the attending physician.
  - C. Return the fully completed form to you **EMPLOYER** who will submit the form to Meritain Health.
- TO THE EMPLOYER:**
- A. Give the form to employee for completion of employee and physician statements.
  - B. Have form returned to you and complete employer's section.
  - C. Submit completed form to Meritain Health.

### TO BE COMPLETED BY THE EMPLOYER

A. Employer \_\_\_\_\_ Division \_\_\_\_\_

B.

Form of Insurance	Account No.	Effective Date of Insurance	Rate of Benefits in Force On Date of Accident or Sickness	Percentage of Employee Contribution
Disability Income				

C. Name of employee \_\_\_\_\_ Sex \_\_\_\_\_

D. Social Security Number \_\_\_\_\_ Telephone Number \_\_\_\_\_

E. Has the employee made claim for, or is he entitled Worker's Compensation Benefits?  Yes  No

F. Employee's occupation \_\_\_\_\_ Basic Weekly Earnings \_\_\_\_\_

G. Date of employee last worked \_\_\_\_\_  AM  PM

H. Prior to this disability was the employee  Laid off  On leave  Retired  Discharged

I. Date returned to work \_\_\_\_\_  AM  PM

J. Employer Tax Identification Number \_\_\_\_\_

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(Authorized representative)(Date signed)

### TO BE COMPLETED BY THE EMPLOYEE

A. Employee's name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (M.I.) \_\_\_\_\_ Date of Birth \_\_\_\_\_

B. Address (Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ Zip Code \_\_\_\_\_  
Employees Telephone Number \_\_\_\_\_

C. Description of accident or sickness \_\_\_\_\_

D. Date of accident or beginning of sickness \_\_\_\_\_  AM  PM

E. Were you at work?  Yes  No Have you or will you file for Worker's Compensation Benefits?  Yes  No

F. Are you insured under any other group insurance or government plan or under automobile mandatory no-fault coverage, which will also pay disability benefits:  Yes  No If yes, give name of insurance company first/party benefit insurer or organization providing benefits.  
Name \_\_\_\_\_  
Address \_\_\_\_\_ Policy No. \_\_\_\_\_

G. Name of doctor \_\_\_\_\_

H. Name and address of hospital \_\_\_\_\_

I. Date entered hospital \_\_\_\_\_ Date discharged \_\_\_\_\_

"I hereby authorize any Dentist, Physician, Hospital, Pharmacy, Insurance Company, Employer or Organization to release any information regarding the medical, dental, mental, alcohol or drug abuse history, treatment of benefits payable including disability or employment related information concerning this claim to the Plan Administrator or its authorized agent for the purpose of validating and determining benefits payable in connection with this claim. This date may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request."

**SIGN HERE** ►

\_\_\_\_\_  
(Employee's signature)

\_\_\_\_\_  
(Date)

