Meritain Health®
an aetna company

Short Term Disability Claim Form

Employee Form

ALL questions must be answered to avoid a possible delay. Please return completed form to employer. Claims are subject to review to determine medical appropriateness.

Employee's Statement of Claim — *Please Print*

Full Name	Member ID	Phone Number	
Mailing Address (if different from street address)	City	State	Zip Code
Employer Name	Email address		
Date of Birth:	Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced	Gender: ☐Male ☐Female	
Is the claim a result of a work related illness or injury? ☐Yes ☐No	Is claim due to an accident/injury? ☐Yes ☐No		
Have you or will you file a claim for workers compensation benefits? ☐Yes ☐No	Please provide a detailed description of how injury occurred and location.		
Date Disability commenced / Date disability ceased			
Have you filed for Social Security Benefits? ☐Yes ☐No	Date that claim was filed:	Date that Social Security benefits commenced:	

Authorization to Release Information: I hereby authorize any providers or Health Care services, claim administrators, insurers, reinsurers and others who have legitimate need for such information for the purpose or review, investigation or evaluation of a claim, to supply each other with information about my health status and the health care services provided to me. I agree that a photographic copy of this authorization is as valid as the original.

_____ _____

Employee Signature Date

Important notice to all employees: Time spent on short-term disability leaves of absence (including any waiting periods) will be deducted from your 12-week leave bank in accordance with the Family Medical Leave Act of 1993

_____Employee initials

Any person who knowingly and with intent to defraud any insurance company or claims administrator or other person files an application for insurance or statement of claim, 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.

_____Employee initials

Treating Physician's Statement — *Please Print*

Diagnosis	ICD10 Code	Disability due to pregnancy? ☐Yes ☐No	Expected delivery date:
Is Disability due to illness or injury arising from Patient's employment? ☐Yes ☐No	Auto related? ☐Yes ☐No	Date of first treatment:	Date of most recent treatment: Date of next appointment:
Describe course of treatment:			Was the patient hospital confined? ☐Yes ☐No From: Through:
The patient has been continuously disabled (unable to work) From: Through:	The patient should be able to work on/or about: (Please indicate a date to avoid a delay in benefits)		Date and type of surgical procedure:
Attending Physician (please print)	Physician's signature (no stamped signatures)		Physician specialty:
Physician's address:	Telephone number: Fax number:		Date:

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Employer Form

Please provide a job description with claim submission.

Employer's Statement		***Please Print***		
Employees Name		Occupation	Hourly ☐ Salary ☐	Employment date
Weekly Wage	Weekly Benefit	Employee Status Active ☐ Laid Off ☐ Retired ☐		Effective date of coverage
Date disability commenced	Date disability ceased	Vacation, Personal, Sick time used: Yes ☐ No ☐ Dates used:		Date last worked
Is this a recurrence within 2 weeks of previous disability? ☐Yes ☐No		Has employee returned to work? ☐Yes, Date_____ ☐No		
Do you have any information which would assist Meritain in determining the merits of this case? Please explain.				
Do you have any information regarding worker's compensation or other disability income benefits that would affect this claim? Please explain				

PLEASE CIRCLE THE JOB DEMANDS THAT APPLY IF JOB DESCRIPTION NOT ATTACHED

Demand Level % of working or frequency	**Occasional** 0-33% 1-4 reps per hour 1-32 reps per day	**Frequent** 34-66% 6-24 reps per hour 33-200 reps per day	**Constant** 67-100% >24 reps per hour >200 reps per hour
Sedentary	10 pounds	Negligible	Negligible
Light	Up to 20 pounds	10 pounds	Negligible
Medium	Up to 50 pounds	20 pounds	10 pounds
Heavy	Up to 100 pounds	50 pounds	20 pounds
Very Heavy	Over 100 pounds	Over 50 pounds	Over 20 pounds

Employee's job requires: _____% Standing _____% Bending _____% Twisting

IF MERITAIN HEALTH ISSUES THE CHECKS, PLEASE INDICATE INDIVIDUAL APPLICABLE DEDUCTIONS

Federal Tax _____% State Tax _____% Other _____%

PRE-TAX DEDUCTIONS		**AFTER TAX DEDUCTIONS**	
MEDICAL INSURANCE	$ _____	CHILD SUPPORT	$ _____
DENTAL INSURANCE	$ _____	SPOUSAL SUPPORT	$ _____
FLEX	$ _____	OTHER _____	$ _____
OTHER _____	$ _____	OTHER _____	$ _____

Employer's representative (please print)	Signature of Employer's representative
Title: Company Name: Group Number: Address: Phone number: Fax number :	Submit claims to: **Meritain Health** Phone: **1.800.748.0003** x2187 Fax: **517.381.6768** Email: Disability@Meritain.com