NATIONAL IAM
BENEFIT TRUST FUND
99 M St, SE, Ste 600
Washington, DC 20003-3799

SHORT TERM DISABILITY CLAIM FORM

INSTRUCTIONS:
1. Have your Employer complete the "Employer Statement."
2. Complete the "Employee Statement" in full.
3. Have your Physician complete the "Attending Physician's Statement" on reverse side.
4. TYPE or PRINT so information is legible.
5. IMPORTANT: To assure timely payment of Short Term Disability benefits, this form must be FULLY COMPLETED and submitted IMMEDIATELY following any injury, illness, or medical treatment that results in loss of work due to disability.

☐ Check if your address has changed since your last enrollment form was completed.

EMPLOYER STATEMENT

SICK LEAVE MUST BE EXHAUSTED BEFORE DISABILITY BENEFITS BEGIN (Plan provides limited exceptions)

1. Employee name: _____ 2. Employee SSN: _____

3. Date employee last worked: _____ 4. Date employee returned, or is *expected* to return, to work: _____

5. Last date for which pay was / will be received: _____ 6. Has employee been terminated? ☐ Yes ☐ No
(Use last date of ***any*** paid hours: worked, vacation, sick leave, etc)

7. Regularly scheduled gross weekly base wages: _____ 8. Work day schedule: ☐M ☐T ☐W ☐Th ☐F ☐Sa ☐Su
(Mark employees regularly scheduled work days)

9. Wages based on how many hours per week? _____ 10. If ordered by employee's physician, is light duty available? ☐ Yes ☐ No
(Number of regular hours)

EMPLOYER NAME: _____ **TAXPAYER ID NUMBER:** _____

EMPLOYER ADDRESS: _____ **PHONE NUMBER:** _____

SIGNATURE: _____ **TITLE:** _____ **DATE SIGNED:** _____
(Authorized employer representative)

EMPLOYEE STATEMENT

I HEREBY APPLY FOR BENEFITS ON ACCOUNT OF DISABILITY

1. Your name: _____ 2. Your SSN: _____

3. Your address: _____ 4. Date of birth: _____
(Street address)

_____ 5. Phone number: _____
(City, State, Zip)

6. Last date worked before disability: _____ 7. Date you were first disabled: _____

8. Date returned to work after disability: _____ 9. Date you *expect* to return to work: _____
(If not already returned to work)

10. Give medical cause of disability: _____

11. Is the disabling condition caused by your occupation? ☐ Yes ☐ No If yes, have you filed a Workers' Compensation claim? ☐ Yes ☐ No

12. Disability is the result of: ☐ Illness ☐ Pregnancy ☐ Accidental Injury (complete 13 below) ☐ Other : _____
(Please explain)

13. Provide details of accident or injury. Date of accident or injury: _____ Time of accident or injury: _____ AM / PM

Where did accident or injury occur? _____

How did accident or injury occur? _____

14. If hospitalized, name of hospital: _____ Phone Number: _____

Date admitted: _____ Time: _____ Date discharged: _____ Time: _____

15. Are you eligible for or receiving any state or other disability income? ☐ Yes ☐ No If yes, please attach a copy of your most recent benefit statement.

16. Do you have group health coverage? ☐ Yes ☐ No If yes, with whom? _____

EMPLOYEE CERTIFICATION AND AUTHORIZATION FOR RELEASE OF INFORMATION

I certify that the above information is true and correct. I authorize all providers of medical care and my employer to furnish the National IAM Benefit Trust Fund or its legal representative with any information necessary to process this claim, including medical and/or employment information. This authorization shall remain valid until the claim has been fully processed or discharged, including any procedures for review or investigation of the claim after payment. I know that I have a right to receive a copy of this authorization upon request. I agree that a photocopy shall be as valid as the original.

EMPLOYEE SIGNATURE: _____ **DATE SIGNED:** _____

SHORT TERM DISABILITY CLAIM FORM

ATTENDING PHYSICIAN S STATEMENT

PLEASE TYPE OR PRINT LEGIBLY

PATIENT NAME: _____ **DATE OF BIRTH:** _____

1. Diagnosis and concurrent conditions: _____

2. Is condition the result of patient's employment? ☐ Yes ☐ No If yes, has a workers' compensation claim been filed? ☐ Yes ☐ No

3. Is condition due to pregnancy? ☐ Yes ☐ No If yes, approximate date pregnancy commenced: _____

Note - Disability certification that exceeds 6 weeks after normal delivery or 8 weeks after cesarean section will require written explanation from attending physician.

4. Is condition due to accidental injury? ☐ Yes ☐ No If yes, please provide accident date: _____

5. Date symptoms first appeared: _____ 6. Date patient first consulted you for this condition: _____

7. Date of patient's most recent visit in your office: _____ 8. Date of next scheduled visit: _____

9. Additional dates of service for this condition: _____

10. Was patient referred to your office? ☐ Yes ☐ No If yes, by whom? _____

11. Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, when? _____

12. Was testing ordered to confirm diagnosis or disability status? ☐ Yes ☐ No Please explain: _____

13. Is patient still under your care for this condition? ☐ Yes ☐ No If no, date released from your care: _____

14. Did you refer patient to another physician? ☐ Yes ☐ No If yes, when and to whom? _____

15. Was there any period of time when this patient was **continuously totally disabled** and unable to perform normal work duties? ☐ Yes ☐ No If yes:

Please specify dates of total disability. From: _____ To: _____

16. Was the patient hospitalized as a result of this disability? ☐ Yes ☐ No If yes: ☐ Outpatient hospitalization ☐ Inpatient admission

Please specify hospitalization dates. From: _____ To: _____

17. Has patient been released to return to work? ☐ Yes ☐ No If yes, date released to return to work: _____

18. If not released, please ***estimate*** date patient will be released to return to work (can be extended later if necessary): _____

19. Does the patient have other health coverage? ☐ Yes ☐ No If yes, please identify: _____

PHYSICIAN NAME / DEGREE: _____

ADDRESS: _____
(Street address)

_____ **SPECIALTY:** _____
(City / State / Zip)

PHONE NUMBER: _____ **FAX NUMBER:** _____

I certify the information provided in this Attending Physician's Statement is true and correct, including any certification of total disability as indicated above.

PHYSICIAN SIGNATURE: _____ **DATE SIGNED:** _____

ADDITIONAL REMARKS: _____

_____

_____

_____

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