



INSTRUCTIONS

This form is to be completed by the employee and the attending physician. Benefits are considered on a bi-weekly basis subject to receipt of required proof of medical evidence by your physician. To avoid delay, please return the completed form promptly.

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

To be completed by Employee

Employee's Full Name _____ Claim No. _____

Address _____ Zip Code _____

1. A. Has your physician discharged you? Yes No If yes, give date _____

B. If No, date of next appointment _____

2. Has your disability terminated? Yes No If yes, give date _____

3. Show date you returned to work _____ OR if still disabled, show
expected date of return _____ AND describe your present activities

Date _____ Employee Signature _____

The Physician's Statement on the reverse side must be completed.



Must be completed by Attending Physician

1. Patient's Name _____
2. Date of next scheduled appointment _____
3. Nature of sickness or injury. (Describe complications, if any) _____

4. If disability is caused by pregnancy, indicate delivery date _____ Type _____
5. A. Date of first treatment _____
B. Date of most recent treatment* _____
C. Frequency of treatments _____
D. Date of surgery _____
E. Nature of surgery _____
F. Date of final discharge _____
6. Dates of total disability: from _____ through _____
Dates of partial disability: from _____ through _____
Date patient able to return to work _____
7. Remarks: _____

Attending Physician's Signature _____

Print Attending Physician's Name _____

Attending Physician's Address _____

Attending Physician's Phone Number _____

Date _____

***Failure to provide this information may delay future benefits.**