

**INSTRUCTIONS**

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

*Any person who knowingly and with intent to defraud any insurance company 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.*

**To be completed by Employee**

Employee's Full Name \_\_\_\_\_ Claim No. \_\_\_\_\_

Address \_\_\_\_\_ Zip Code \_\_\_\_\_

1. A. Has your doctor 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 \_\_\_\_\_ Signed \_\_\_\_\_

**To be completed by Employer**

Has employee returned to work?  Yes  No IF YES, GIVE DATE \_\_\_\_\_

If no, what date is the employee expected to return? \_\_\_\_\_

If not returning, when was this employee terminated? \_\_\_\_\_

Date \_\_\_\_\_ Signed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Title \_\_\_\_\_

**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.**