Group Plan Solutions
Benefit Administration
A Division of Pekin Insurance®

GROUP PLAN SOLUTIONS
PO Box 1587 • Pekin, Illinois 61555-1587
www.groupplansolutions.com
(888) 301-0747 • Fax: 855-545-7165

DISABILITY CLAIMANT'S STATEMENT

MEMBER INFORMATION

Member Number: ____________________ Member's Name: ____________________

Address: ____________________ City: ____________ State: __________ Zip: __________

Date of Birth: ____________________ Telephone Number: ____________________

EMPLOYER INFORMATION

Employer's Name: ____________________ Group Number: ____________________

Employer's Address: ____________________

Occupation: ____________________ Has your employment terminated? ______

Substantial Duties (Be specific): ____________________

____

DESCRIBE DISABILITY

Describe the accident or illness fully: ____________________

____

Date accident or illness began: ____________________ Date symptoms first appeared: ____________________

Date first treated: ______________ Dates of medical treatment: ____________________

Date of next doctor's appointment: __________ If hospitalized, Admit Date: __________ Discharge Date: __________

Full name and address of hospital: ____________________

____

Name and address of first physician seen: ____________________

Name and address of family doctor: ____________________

Names and addresses of all treating physicians and/or hospitals: ____________________

____

Have you ever had the same or similar condition in the past? ______ If yes, please list the names and addresses of treating physicians and/or hospitals: ____________________

TOTAL DISABILITY

Last date worked: ______________ First date of disability: ______________ Date you returned to work: __________

If you have not returned to work, when is your anticipated return date? __________ Dates you were unable to perform all of the substantial and material duties of your occupation due to this illness or injury: From ________ To ________

PARTIAL DISABILITY

Have you worked any full or partial days since your disability began? ________

List the duties of your job you could not perform during any period of time you were partially disabled: ______________

____

Dates of partial disability: From ___________ To ____________

DISABILITY CLAIMANT'S STATEMENT (Continued)

UNEMPLOYMENT BENEFITS

Have you applied for or are you receiving unemployment benefits? _________________

First date eligible?__________________ Date first check received? ________________

WORKER'S COMPENSATION

Is this condition the result of a work related incident?________

Have you filed or are you going to file a worker's compensation claim? _______

OTHER INCOME

Name, address and phone number of any other disability carrier: ____

____

Amount of benefit received from other disability carrier: ____________

Annual salary for the 2 years prior to your disability: Year 1 $ ____________ Year 2 $ ____________

Have you applied for or are you receiving Social Security Disability? ____ Please include a copy of your reward or denial.

Identify any other income sources and amount of income for which you are receiving or may be entitled to receive during this disability. ____

AUTHORIZATION

GROUP PLAN SOLUTIONS or its representatives are hereby authorized to examine and secure copies of any medical records, including information relating to mental illness, and drug and alcohol use, employment records, governmental records, records of other insurance companies, or other records or information. A copy of this authorization shall be considered as valid as the original.

I understand that such information will be used by Group Plan Solutions for the purpose of evaluating my claim for insurance benefits. I or any authorized representative will receive a copy of this authorization upon request. I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. Group Plan Solutions may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. This authorization is valid for the date signed for the duration of the claim. You may revoke this authorization at any time by signing and dating the revocation section and returning it to this office at the address listed above. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization. I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

SIGNATURE

I hereby certify that the answers given on pages 1 and 2 of this statement are full and true:

Claimant's Signature: ____ Date: _____________

AUTHORIZATION REVOCATION (Only sign here if you wish to revoke your authorization.)

Claimant's Signature: ____ Date: _____________

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ATTENDING PHYSICIAN'S STATEMENT

MEMBER INFORMATION

Patient's Name: ____________________ Date of Birth: ____________

Address: ____________________ City: __________ State: ________ Zip: ________

Group Name: ____________________ Member Number: ____________

DIAGNOSIS AND TREATMENT

1. Diagnosis and concurrent conditions ____________________

____

2. (a). Is condition due to injury or sickness arising out of patient's employment? ❑ yes ❑ no

   If yes, explain ____________________

   (b). Is condition due to pregnancy? ❑ yes ❑ no If yes, approximate date pregnancy began ____________

3. (a). Date of accident or first symptoms of illness ____________________

   (b). Date patient first consulted you for this condition ____________________

   (c). Give all other dates of treatment in office ____________________

   (d). If patient was hospitalized, name and address of hospital ____________________

   ____

   (e). Dates hospitalized ____________________

   (f). Nature of surgical procedure, if any ____________ Date performed ____________

4. Has patient ever had same or similar condition? ❑ yes ❑ no If yes, when ____________

5. Is patient still under your care for this condition? ❑ yes ❑ no If no, date last treated ____________

DISABILITY CERTIFICATION

6. (a). Dates patient was totally disabled (Unable to work): From __________ To __________

   (b). Dates patient was partially disabled: From __________ To __________ w/ restrictions of: __________

   ____

   (c). If disability continuing, when will patient be able to return to work? ____________________

PHYSICIAN'S SIGNATURE

____________________ Attending Physician – Signature Degree

____________ Date

____________ Phone Number

____________________ Attending Physician – Print

____________ Federal Tax I.D. Number

____________ Fax Number

Street Address: ____________________ City: __________ State: ________ Zip: ________

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EMPLOYER'S REPORT

MEMBER INFORMATION

Member Number: ____________________ Member's Name: ____

Street Address: __________________________________ City: _____________ State: __________ Zip: _________

EMPLOYMENT INFORMATION (To be completed by the employer or timekeeper.)

1. Date first employed by your company _____________
2. On what date did accident occur or sickness commence? _________________ hour ________ ❑ a.m. ❑ p.m.
3. On what date did employee stop work? _______________________________ hour ________ ❑ a.m. ❑ p.m.
4. What is employee's occupation? ____

   What are employee's usual duties? ____
5. Full time employee? ❑ yes ❑ no

   Within the last two years, has employee ever worked less than 30 hours per week (other than vacation)? ❑ yes ❑ no

   If yes, please list dates ____

   Part time employee? ❑ yes ❑ no If part time, how many hours worked per week? _________________________
6. On what date did employee first return to work? ________________________ hour _______ ❑ a.m. ❑ p.m.
7. If partially disabled, what duties of employee's regular job was he/she able to perform? ______________________

   ____
8. On what date did employee return to full duty? __________________________ hour _______ ❑ a.m. ❑ p.m.
9. If still disabled, is position being held for employee? ❑ yes ❑ no

SIGNATURE

Name of Employer: ____ Telephone No.: _______________________

Group Number: ___________________________________

Street Address: __________________________________ City: _____________ State: __________ Zip: _________

Print Name: _____________________________________ Official Position: _________________________________

Signature: ____ Date: _____________