HealthPlans
A HARVARD PILGRIM COMPANY

Claim Service provided by:

Health Plans, Inc.
P.O. Box 5199
Westborough, MA 01581

Call (508) 752-2480
or
Toll-Free (800) 532-7575

www.healthplansinc.com

SHORT TERM DISABILITY

The following statement is to comply with the requirement of various states: Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information, is guilty of a felony.

PART A - EMPLOYER STATEMENT

Policy Number	Employer	Address

Name Employee	Date Employed	☐ Full-Time ☐ Part-Time	No. Hrs. Per Week

Occupation/Duties

Identify (If Applicable)

☐ Owner ☐ Partner ☐ Officer of Firm

Effective Date of Insurance ___ Last Date Paid ___

Last Date Worked ___ Date Work Resumed ___

Is This Employee Entitled To Benefits From:

- Workmen's Compensation ☐
- Health or Welfare Plan ☐
- Salary Continuance Plan ☐
- Retirement or Pension Plan ☐

Identify

Employment Terminated ☐ Yes ☐ No

Date

Insurance Terminated ☐ Yes ☐ No

Date

Premium. Specify manner by which premiums were paid on this policy
☐ Employee paid 100% ☐ Employer paid 100% ☐ Cost Sharing

a Employee's contribution % ___
b Employer's contribution % ___

Date Signature Title

PART B - EMPLOYEE'S STATEMENT

Name of Employee	Social Security Number	Date of Birth

Address (No Street, City, State & Zip Code)	Phone Number

Date You Last Worked	When Did You Become Continuously Totally Disabled (First Date Unable to Work) Date Time

Cause of Disability	Did Illness or Injury Occur in the Course of Employment? ☐ Yes ☐ No

If Hospitalized, Give Name of Hospital	Dates Confined To Hospital (To - From)
If Returned To Work, Give Date	If Not, When Do You Expect To Return To Work?
Attending Physician	Address

I authorize any physician, hospital, insurer or other organization or person having any records, data or information concerning me or my minor dependents to furnish such records, data or information as may be requested by such Companies to Health Plans, Inc. or their duly authorized representatives. I understand that in executing this authorization, I waive the right for such information to be privileged. A photocopy of this authorization shall be considered as effective and valid as the original.

EMPLOYEE SIGNATURE _____ DATE _____

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

The patient is responsible for the completion of this form without expense to the Company.

NAME OF PATIENT

1. HISTORY
   (a) WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN? — MO. _____ DAY _____ 19 _____
   (b) DATE PATIENT CEASED WORK DUE TO DISABILITY — MO _____ DAY _____ 19 _____
   (c) HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? — ☐ YES ☐ NO
   IF YES STATE WHEN AND DESCRIBE
   (d) Is Condition Due to Injury or Sickness Arising Out of Patient's Employment?

2 PRESENT CONDITION
   (a) SUBJECTIVE SYMPTOMS
   (b) OBJECTIVE FINDINGS *(Include results of current X-Rays, EKG's, or any other special tests)*
   (c) IS PATIENT — ☐ AMBULATORY ☐ BED CONFINED ☐ HOUSE CONFINED ☐ HOSPITAL CONFINE

3 DIAGNOSIS
   (If surgery involved give nature of surgical operation)

4. TREATMENT
   (a) DATE OF FIRST VISIT — MO. _____ DAY _____ 19 _____
   (b) DATE OF LAST VISIT — MO _____ DAY _____ 19 _____
   FREQUENCY OF VISITS — ☐ WEEKLY ☐ MONTHLY ☐ OTHER
   (c) WHEN DID YOU LAST EXAMINE THE PATIENT — MO _____ DAY _____ 19 _____

5. PROGRESS
   ☐ RECOVERED ☐ IMPROVED ☐ UNIMPROVED ☐ RETRO-GRESSE

6. DURATION OF TOTAL DISABILITY
   (a) IS PATIENT NOW TOTALLY DISABLED? *(i e unable to do any work)*
   FOR HIS REGULAR OCCUPATION ☐ YES ☐ NO
   FOR ANY OCCUPATION ☐ YES ☐ NO
   (b) IF NO, WHEN WAS PATIENT ABLE TO GO TO WORK? — MO. _____ DAY _____ 19 _____
   (c) IF YES, WHEN DO YOU THINK PATIENT WILL BE ABLE TO RESUME WORK? — APPROXIMATE DATE MO. _____ 19 _____ / INDEFINITE ☐ / NEVER ☐

7. IF PATIENT HAS NOT RETURNED TO WORK IS HE A SUITABLE CANDIDATE FOR A REHABILITATION PROGRAM? — ☐ YES ☐ NO

8. CARDIAC
   (a) FUNCTIONAL CAPACITY — ☐ CLASS 1 *(No Limitation)* ☐ CLASS 2 *(Slight Limitation)* ☐ CLASS 3 *(Marked Limitation)* ☐ CLASS 4 *(Complete Limitation)*
   (b) BLOOD PRESSURE

9 Have You Completed Other Disability Insurance Forms?

YES ☐ NO ☐ If "YES" Please Identify Carrier or Employer.

DATE | SIGNATURE *(Attending Physician)* | DEGREE | TELEPHONE

STREET ADDRESS | CITY OR TOWN | STATE | ZIP CODE