HealthPlans, Inc.

Weekly Disability Claim Form

Employer Name: _____ **Group Number:** _____

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.***

PLEASE PRINT OR TYPE WHEN COMPLETING THIS FORM

Section 1: Employee Information

Employee Last Name	*First Name*	*MI*	*Health Plans Member ID#*	*Date of Birth*

Mailing Address	*City*	*ST*	*ZIP Code*

Social Security #	*Primary Phone#*	*Email Address*	*Occupation*

Is this claim due to an accident or illness?	Date of accident or onset of illness:
Location (address if known) of accident or onset of illness:	

Were you working for your employer at the time of the injury or onset of illness?	Was the injury or onset of illness related to your employment duties?	Have you filed a Worker's Compensation claim for this condition?

Please describe how the injury or onset of illness occurred:

The above statements are true and correct to the best of my knowledge and understanding. I hereby authorize any hospital, physician or any other organization, institution, company, governmental agency or person who has examined or attended to me, or who has my records or knowledge of me or my health, to furnish to Health Plans, Inc. and its authorized representatives any and all information with respect to any illness or injury, medical history, consultation, prescriptions, treatment or benefits, and copies of all hospital records or any other documentation. I also agree a photocopy of this authorization shall be as valid as the original.

Signature: _____ _____

Signature of Employee *Date Signed*

Section 2: Attending Physician's Information and Statement

Physician's Full Name	*Physician's Phone#*	*Date Signed*

Physician's Address	*City*	*ST*	*ZIP Code*

Patient's Diagnosis (ICD-10 Code)	*Patient's Current Condition(s)*

Date injury or onset of illness occurred:	Date patient first consulted you:	Is the patient pregnant?	If yes, expected date of delivery:

Date of hospitalization: ☐ n/a	Dates of continuous total disability: From	through

Is the patient's present condition a result of their employment?	Is the patient totally disabled from performing his/her job?	Is the patient currently under your care due to this condition?	Date of next appointment: ☐ n/a

Physician's Signature:

Section 3: To Be Completed by Employer

Policy#	*Date Last Worked*	*Date Returned to Work*	*Weekly Earnings* $	*# Hours/Week*

Has a Worker's Compensation claim been filed?	If not, will a Worker's Compensation claim be filed?

Signature of Employer's Representative	***Employer's Representative*** *(please print)*

Title	*Phone#*	*Date*