NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

IMPORTANT: USE THIS FORM ONLY WHEN THE CLAIMANT BECOMES SICK OR DISABLED WHILE EMPLOYED

PART B – HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type)
THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY AND THE FORM *MAILED TO THE INSURANCE CARRIER OR SELF-INSURED EMPLOYER, OR RETURNED TO THE CLAIMANT WITHIN SEVEN DAYS* OF THE RECEIPT OF THE FORM. For item 7d, give approximate date. Make some estimate. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date under "Remarks."

1. Claimant's Name _____ 2. Age _____ 3. ❑ Male ❑ Female
4. Diagnosis/Analysis _____ Diagnosis Code _____
   a. Claimant's Symptoms _____
   _____
   b. Objective Findings _____
   _____
5. Claimant hospitalized? ❑ Yes ❑ No From _____ To _____ CPT Code _____
6. Operation indicated? ❑ Yes ❑ No a. Type _____ b. Date _____
7. Enter dates for the following:

	Month	Day	Year
a. Date of your first treatment for this disability.....			
b. Date of your most recent treatment for this disability.....			
c. Date claimant was unable to work because of this disability.....			
d. Date claimant will be able to perform ususual work..... (Even if considerable question exists, estimate date. Avoid use of terms, such as unknown or undetermined.)			

8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease?
   ❑ Yes ❑ No If "Yes," has form C-4 been filed with the Worker's Compensation Board? ❑ Yes ❑ No
   Remarks: (attach additional sheet, if necessary) _____
   (If disability is pregnancy related, please enter estmated delivery date.)

I affirm that I am a				Licensed in the State of	License Number
	❑ Chiropractor ❑ Dentist	❑ Physician ❑ Podiatrist	❑ Psychologist ❑ Nurse-Midwife		

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL, STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO FINES AND IMPRISONMENT.

Health Care Provider's Signature _____ Date _____
Health Care Provider's Name *(Please Print)* _____ Tel. No. _____
Office Address _____
Number Street City or Town State Zip Code

Employer's Statement Policy Number: _____
Employee's Full Name *(as shown on Social Security card):* _____ S.S. Number: _____
Employee's Address: _____ Date of Birth: _____
Employee's Occupation: _____ Date Employed: _____ ❑ Full Time ❑ Part Time
Is employee a Union member? ❑ Yes ❑ No Check days normally worked:
If "Yes," is employee eligible for Union benefits? ❑ Yes ❑ No

Mon	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.

If Part Time, give particulars: _____
Date employee last worked: _____
Date employee returned to work: _____
Were wages continued during disability? ❑ Yes ❑ No
Were wages Sick pay? ❑ Yes ❑ No From: _____ To: _____
Were wages Vacation pay? ❑ Yes ❑ No From: _____ To: _____
Is reimbursement requested? ❑ Yes ❑ No
Is disability due to job? ❑ Yes ❑ No
If "Yes," has a compensation claim been filed? ❑ Yes ❑ No
Indicate Weekly Value of Board, Lodging and Tips: _____
Employer's Name: _____
Employer's Identfication No.: _____

EARNINGS 8 WEEKS PRIOR TO DISABILITY
(Including the week in which the disability began)

Month	Day	Year	No. Days Worked	Amount
			Total	

Is this employee currently covered by Social Security? ❑ Yes ❑ No If "No," state grounds for exemption: _____
_____
Address: _____ Telephone No. _____
Signed by: _____ Title: _____ Date _____