Disability Insurance Claim Form

Employee's Statement: To be completed by the Employee

A. About You

Name of Employee	Date of Birth	__ Single __ Divorced __ Married __ Widowed __ Legally Separated
Address	Soc. Sec. No.	
City, State & Zip	Place of employment:	

B. About The Claim

This Claim is Due to:		
(complete one of these sections)	**An Injury**	Date _____ Where did it occur?_____ How did it happen?_____ _____ Was the accident connected with Patient's Employment ___ Yes ___No
	A Sickness	When did Symptoms begin? _____ Date First Consulted by Physician_____ Name of Doctor_____

C. Physician Or Supplier Information

Has Patient Ever Had Same or Similar Symptoms? ☐ Yes ☐ No	**Dates of Patients Disability**	
	Total Disability	**Partial Disability**
Date Patient should be able to return to work.	From Date Through Date	From Date Through Date
Name of Referring Physician		
For Services Related to Hospitalization Give Hospitalization Dates	Date Admitted	Date Discharged
Name and Address of Facility Where Services Rendered (If other than Home or Office)		
Diagnosis or Nature of Illness or Injury Requiring Services or Supplies		

The statements above are true and correct to the best of my belief. I Authorize any Hospital or Physician to furnish Administrative Claim Service any information requested. Also, I hereby Authorize my Employer or Administrative Claim Service to release to or obtain from any organization, or person or regulatory agency any information which may be necessary to determine benefits payable under the Benefit Plan. A photostatic copy of this Authorization shall be considered as effective and valid as the original.

_____

Employee's Signature Date

WHEN COMPLETE, PLEASE MAIL OR FAX TO:

Taylor Benefit Resource, Inc.
P. O. Box 6580
Thomasville, GA 31758
888-35-CLAIM - FAX (229) 225-9945