

IMPORTANT: Failure to return this form promptly may result in the delay of payment for disability benefits.

| Part 1 - To be completed by EMPLOYEE | |
|---|---|
| Name of Employee | Date: |
| Address | |
| Date of Birth | Health Care Identification Number (HCID): |
| Daytime Phone Number | |
| Date and time of the accident or onset of disability. | |
| Where did the accident or onset of disability occur? | |
| Is this condition/injury related to employment? | |
| If due to an accident, please provide details of how the accident occurred. | |
| First date you were unable to work? | |
| Have you returned to work? If yes, please provide the exact date. | |
| List any dates you have worked between the first day you were unable to work and the date on this form. | |

Medical History Release Authorization

I authorize any medical information relating to this claim to be disclosed to and acquired by the Administrator of this Plan and such agents of the Administrator as are necessary to process this claim. Such information may be disclosed by a health care provider or other plan administrator. This authorization shall remain valid as long as I am disabled and required to provide weekly disability verification(s). I agree that a photocopy of this authorization shall be valid as an original signature.

Employee Signature: _____

| Part 2 - To be completed by PHYSICIAN | | |
|--|-------------|-----------|
| This information is required to initiate Weekly Disability Benefits; follow-up verification may be requested. | | |
| Diagnosis of employee ▪ ICD-9 code(s) | | |
| Date the employee first sought treatment | | |
| Is the condition/injury related to the employee's employment? | | |
| Is the condition/injury related to an accident? | | |
| Symptoms | | |
| Activities permitted with current condition/injury | | |
| Was this employee referred to you? If so, please list his/her name, address and phone number. | | |
| Have you referred this employee to any other physician(s)? If so, please list their name, address and phone number. | | |
| Is the employee still under your care? If no, please provide the date of the last visit. | | |
| Dates of Disability (i.e., Total and Continuous Disability) | Start Date: | End Date: |

| To be completed by PHYSICIAN (continued) | | | |
|--|----------------------------|---------------------------|-----------------------------------|
| Have any surgical procedures been performed? If so, please list. | Surgery Date(s) | Type of Surgery Performed | If hospitalized for this surgery: |
| | | | Date Admitted |
| | | | Date Discharged |
| | | | |
| | | | |
| Other than the surgical procedures listed above, has this patient been hospitalized? If so, please list. | Reason for hospitalization | | Date Admitted |
| | | | Date Discharged |
| | | | |
| | | | |
| | | | |
| Other medical, non-surgical treatments? | | | |

| Verification by PHYSICIAN | |
|-------------------------------------|--|
| Physician's Signature | |
| Physician's Name (please print) | |
| Degree/Practice Specialty | |
| Physicians Office Address | |
| Physician's Office Telephone Number | |
| License Number | |
| Federal Tax ID Number | |