CBA Blue

SHORT TERM DISABILITY CLAIM FORM

INSTRUCTIONS: Employee *MUST* complete "Employee" section, and Human Resources Department completes "Employer" section. Have your physician complete the "Attending Physician Statement", then mail *ALL COMPLETED SECTIONS* to:

CBA BLUE / Short Term Disability - PO Box 2365 So Burlington, VT 05407 Phone: (888)222-9206 FAX: (802)846-2755

SECTION 1: EMPLOYEE

NAME _____ SEX _____ DATE OF BIRTH _____/_____/_____ SOC SEC # _____-_____-_____

ADDRESS _____

HOME TEL. # ( ) _____-_____ WORK LOCATION _____ DATE LAST WORKED _____/_____/_____

DATE ACCIDENT OCCURRED or SICKNESS BEGAN _____/_____/_____ IS THIS CONDITION RELATED TO EMPLOYMENT? ☐ YES ☐ NO

ARE YOU EMPLOYED ELSEWHERE? ☐ YES ☐ NO ☐YES, _____
Company Name & Address

IF INJURED, HOW AND WHERE DID INJURY OCCUR? _____
(MUST BE COMPLETED)
_____

ARE YOU APPLYING FOR ANY OTHER BENEFITS? YAUTOMOBILE NO FAULT ☐ YWORKERS' COMPENSATION ☐OTHER

_____ _____ (____)_____- _____
Carrier Name Carrier Address Carrier Tel. #

DESCRIBE YOUR JOB & EXPLAIN WHY YOUR CONDITION KEEPS YOU FROM WORKING _____
_____

DO YOU HAVE MORE THAN ONE DOCTOR TREATING FOR THIS DISABILITY? ☐YES ☐NO

IF YES, _____ _____ (___)_____- _____
Name Address Physician Tel. #

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM:

Signed: _____ DATE _____/_____/_____
(PATIENT'S or AUTHORIZED PERSON'S SIGNATURE)

SECTION 2: EMPLOYER

COMPANY NAME _____ DIVISION _____

ADDRESS _____

EMPLOYEE'S DATE OF HIRE _____/_____/_____ EFFECTIVE DATE OF COVERAGE _____/_____/_____

ANNUAL SALARY $_____.DATE LAST WORKED _____/_____/_____ DATE WORK RESUMED _____/_____/_____

OCCUPATION _____

PLEASE CHECK ONE IF APPLICABLE: ☐ EXEMPT ☐ NON-EXEMPT ☐ HIGH PLAN ☐LOW PLAN ☐UNION ☐ NON-UNION

IS CLAIMANT ELIGIBLE FOR WORKER'S COMPENSATION ? ☐ YES ☐NO ☐DISPUTED

COMMENTS _____
_____

Signed _____ DATE _____/_____/_____
(SIGNATURE OF EMPLOYER'S REPRESENTATIVE)

SECTION 3: ATTENDING PHYSICIAN

(1.) PATIENT'S NAME _____ HEIGHT & WEIGHT _____

(2) IS THE CONDITION RELATED TO PATIENT'S OCCUPATION? ☐ YES ☐ NO EXPLAIN_____

_____ _____

(3) IS THIS DISABILITY THE RESULT OF: ☐ ILLNESS ☐ INJURY ☐ PREGNANCY - GIVE ESTIMATED DUE DATE_____/_____/_____

ICD-9 PRIMARY _____ **ICD-9 SECONDARY** _____

COMPLICATIONS _____

(4.) FIRST TREATMENT _____/_____/_____ MOST RECENT TREATMENT _____/_____/_____ LIST ALL DATE OF

TREATMENT FOR THIS DISABILITY _____

(5) LIST RELEVENT TESTS PERFORMED/DATES/RESULTS AND MEDICATIONS_____

_____

(6) WHAT IS THE NATURE OF YOUR TREATMENT FOR THIS CONDITION? (INCLUDE OBJECTIVE FINDINGS AND ANY REMARKS) _____

_____

_____

(8) IS OR HAS THE PATIENT BEEN TOTALLY DISABLED FROM PERFORMING HIS/HER OCCUPATION? ☐ YES ☐ NO

GIVE TOTAL DISABILITY PERIOD: ☐ ACTUAL ☐ ESTIMATED FROM _____/_____/_____ THROUGH _____/_____/_____
(AN ESTIMATE MAY IMPACT OUR ABILITY TO PAY BENEFITS TO YOUR PATIENT)

(9) STATE SPECIFICALLY HOW / WHY THIS CONDITION PHYSICALLY AND/OR MENTALLY PREVENTS THE PATIENT FROM PERFORMING HIS/HER NORMAL OCCUPATION _____

_____

(10) WHAT PROGRESS IS THE PATIENT MAKING IN REGARDS TO HIS/HER CONDITION?

☐RECOVERED ☐ IMPROVED ☐ UNIMPROVED ☐ REGRESSED

(11) PATIENT'S CURRENT PHYSICAL IMPAIRMENT (As defined in the Federal Dictionary of Occupational Titles):

☐ Class 1 - No Limitation of Functional Capacity: Capable of Heavy Work. No Restrictions (0-10%)

☐ Class 2 - Medium Manual Activity (15-30%)

☐Class 3 - Slight Limitation of Functional Capacity: Capable of Lighter Work (35-55%)

☐ Class 4 - Moderate Limitation of Functional Capacity: Capable of Clerical Administrative (Sedentary) Activity (60-70%)

☐ Class 5 - Severe Limitation of Functional Capacity: Incapable of Minimum (Sedentary) Activity (75-100%)

ARE ACTIVITIES RESTRICTED? ☐YES ☐ NO PLEASE INDICATE RESTRICTIONS _____

_____

WHEN WILL THE PATIENT BE ABLE TO RETURN TO WORK AT HIS/HER REGULAR OCCUPATION? _____/_____/_____

OR TO OTHER LIGHT /PARTIAL DUTY ? _____/_____/_____(Even if considerable question exists, estimate date. Avoid use of such terms as Unknown or Undetermined)

(12) IS OR HAS THE PATIENT BEEN HOSPITALIZED OR HAD EMERGENCY ROOM TREATMENT? ☐YES ☐NO

DATE ADMITTED_____/_____/_____ DISCHARGED _____/_____/_____ ER TREATMENT _____

(13) SURGERY PERFORMED? ☐ YES ☐ NO DATE _____/_____/_____ **CPT CODE** _____

PHYSICIAN'S NAME _____ PROFESSIONAL DEGREE _____
Please Print

TIN #_____ BOARD CERTIFIED SPECIALTY _____

I HEREBY CERTIFY THAT THE INFORMATION ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

PHYSICIAN'S SIGNATURE _____ DATE _____/_____/_____