Group Disability Claim

Save Time and Paper – File Your Claim Online!

We offer two ways to file your Disability claim: online or by mail/fax.

Warning: Any person who knowingly and with intent to injure, defraud, or deceive an insurer les a statement of claim containing any false, incomplete, or misleading information may be guilty of insurance fraud and subject to criminal and civil penalties.
California - For your protection, California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to nes and con nement in state prison.
AR, DC, LA, MD, NJ, NM, TX, and WV - ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT

American Fidelity Assurance Company

Mail to: AFES Bene ts Department
P.O. Box 25160
Oklahoma City, OK 73125-0160
Local: (405) 523-5025
Toll Free: 1-800-662-1113
Fax: 1-800-818-3453
www.american delity.com

EMPLOYEE'S DISABILITY BENEFITS APPLICATION

Full Name: (last, rst, middle initial)	Maiden Name	Account Number:
Residence: (street, city, state and zip code)		Social Security N
Mailing Address: (P.O. Box or street, city and zip code)		
Telephone Number: (including area code) ( )	ˆ Single	
Occupation:	Has y	
Names & birth dates of spouse & dependents:	Name	
1. Date accident or illness began:		
3. Have you ever had the sa If yes, names and add		
4. Nature of illness or i		
6. If hospitaliz of hospital		
7. Full nam (attac		
9. On O		
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EMPLOYER'S REPORT OF CLAIM

Name of Employer: Phone No.:

Mailing Address: (include street, city, state and zip code) Fax No.:

Name of Employee: Social Security Number:

Address: (include street, city, state and zip code) Phone No.:

Date of Hire: Effective date of employee's coverage: Occupation: (please attach job description)

Status of employment at time employee last worked: ˆ Full-Time ˆ Part-Time ˆ Leave of Absence ˆ Terminated ˆ Retired

Number of hours worked per week at time of leave:______________________

Number of contract days: _______________________ for ____________ school year.

Has employee's status of employment changed? ˆ Yes ˆ No If yesStaTxt<FEFF0009>>> BDC Part-Time (Pro)Tj EMC 41.623 0 Td [(Phone No.)-15( )]TJ -41.62f -ro

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ATTENDING PHYSICIAN'S STATEMENT

Name of Patient: | Date of Birth: | Social Security Number: | Account Number:

DIAGNOSIS

Diagnosis: (including complications) ICDA Code:

Is disability due to injury or sickness arising out of or in the course of patient's employment? ^ Yes ^ No

Is disability the result of pregnancy? ^ Yes ^ No If yes, type of delivery: _____

Date pregnancy was diagnosed? ____/____/____ Date of delivery:(if delivered) ____/____/____ Expected date of delivery? ____/____/____

HISTORY

When did symptoms rst appear or accident happen? Date patient rst consulted you for this condition?

_____/_____/_____ _____/_____/_____

Has the patient ever had the same or similar condition? ^ Yes ^ No If yes, indicate when and describe:

Was the patient referred to you? ^ Yes ^ No If yes, full name and address of referring physician:

TREATMENT

Frequency of treatment: ^ Monthly ^ Weekly ^ Other

Date of next appointment : _____/_____/_____

Nature of treatment being rendered (including surgery and any medications being prescribed)

List all dates of treatment or medical attention since the disability began:

Is patient still under your regular care for this condition? ^ Yes ^ No If no, please explain and provide name of the current treating physician:

Has the patient been con ned to a hospital? ^ Yes ^ No Admitted: _____/_____/_____ Discharged: _____/_____/_____

If yes, give admit and discharge dates along with name and address of hospital. Admitted: _____/_____/_____ Discharged: _____/_____/_____

Name:_____ Address: _____

PROGNOSIS

Dates of total disability: (unable to work) From: _____ Through: _____

Disabled from: Patient's Job ^ Yes ^ No Any other work ^ Yes ^ No

Dates of partial disability? From: _____ Through: _____

If the patient is currently disabled, what is the anticipated length of disability?

^ 1-2 Months ^ 2-3 Months ^ 3-6 Months

^ 6-12 Months ^ More than 12 Months ^ Permanent

When, in your opinion, will the patient recover sufficiently to return to work?

IMPAIRMENTS

Functional Limitations that render your patient totally disabled:

Current Treatment Plan:

Attending Physician's Name: (print) | Specialty: | Telephone #: ( ) - | Fax #: ( ) -

Street Address: | City: | State: | Zip Code:

Signature: | Federal Tax ID #: | Date:

Email address: