Auxiant™
Your Integrated Benefits Partner

SHORT TERM DISABILITY CLAIM FORM

*** * * * * TO BE COMPLETED BY EMPLOYEE * * * * ***

Employer Name **Group Number**

Employee Last Name First MI Member ID#

Street Address Date of Birth ☐Male ☐Female

City State Zip Marital Status

Is the disability due to accident or sickness? (If accident, describe, including date & place. If sickness, when did symptoms first appear?)

Have you been confined to a hospital? ☐No ☐Yes If yes, when? From to

Did the disability result from employment? ☐No ☐Yes If yes, give amount of benefit you are receiving from Worker's Compensation $

These statements are true and complete to the best of my knowledge. I authorize my insurer, physician, or hospital to disclose any information regarding my insurance coverage or medical history.

Date: Signature of Insured:

*** * * TO BE COMPLETED BY CONTRACTOR OR UNION HALL * * ***

Employee Name Employee Occupation

Date ☐Employee Coverage effective:

If the coverage has been canceled, give date and reason:

Has this coverage been considered in connection with Worker's Compensation coverage? ☐No ☐Yes

If claim is made on employee, give a) Date Last Worked _____ b) Date Returned to Work_____

Is this a claim for disability benefits? ☐No ☐Yes

(a) Prior to disability was employee ☐Active ☐Laid Off ☐On Leave ☐Retired ☐Discharged

(b) Hourly Rate $: Journeyman: Yes ☐ No: ☐

Comments

Signature of Authorized Representative Date Employer

*** * * * * ATTENDING PHYSICIAN'S DISABILITY STATEMENT * * * * ***

Date symptoms first appeared or accident occurred: Date patient first consulted you for this condition:

Has the patient ever had the same or a similar condition? ☐No ☐Yes Is patient still under your care for this condition? ☐No ☐Yes

Patient was ☐Partially ☐Totally disabled (unable to work) If still disabled, date patient should be able to return to work:
Since:

Diagnosis and concurrent conditions (If diagnosis code other than ICDA, give name):

Is condition due to injury or sickness arising out of patient's employment? ☐No ☐Yes

Is condition due to pregnancy? ☐No ☐Yes If yes, approximate date pregnancy commenced.

Date Physician's Name (Please print) Degree Individual Practitioner's SS#

Physician's Signature Date All Other—Employee FEIN

Street Address City State Zip Telephone

NOTE: Short Term Disability checks are based upon information provided. If this information changes, which results in an overpayment, the employee is responsible to pay the overpayment back to the Plan.

Send completed forms to:
Auxiant
PO Box 75008
Cedar Rapids, IA 52407-5008