P. O. Box 10787
Burbank, CA 91510-0787
(800) 350-0148

GROUP WEEKLY INDEMNITY BENEFITS CLAIM FORM

EMPLOYEE'S STATEMENT

Name: _____ Soc. Sec. No.: _____

Date of Birth (MM/DD/YY): _____ Male ( ) Female ( )

Address: _____

On what date were you first disabled (MM/DD/YY): _____
What is the cause of your disability (if accident, please state when, where and how it occurred)?

_____

_____

Did cause of disability arise out of or during the course of your employment? Yes ( ) No ( )

If you have returned to work, please give date (MM/DD/YY): _____

If you have not returned to work, when do you expect to ?(MM/DD/YY) _____

I hereby authorize any physician or hospital to furnish and disclose all known facts to an authorized representative concerning this disability, a copy or photocopy of this original shall be as valid as the original.

_____ _____
Employee's Signature Date

EMPLOYER'S STATEMENT

Employee's Name: _____ Hire Date: _____ Division: _____

Class Code: _____ Effective Date: _____ Premium Amount: _____

Date employee last worked: _____ Date employee returned to work: _____

If accident, please give date and how did accident happen: _____

_____

Employee basic weekly salary: _____ Occupation: _____

Is there a possibility of workman's compensation liability in this case? Yes ( ) NO ( )
Status of employee when claim incurred: Active ( ) On leave ( ) Retired ( )

If not actively employed, give last date actively at work: _____

If on leave or retired, please give date: _____

Is there any income from other sources such as retirement, sick pay, pension, or annuity benefits which need to be coordinated. YES ( ) NO ( ) - if yes, complete dates in which these benefits were received with this claim?

From: _____ Through: _____

Completed by: _____ Title: _____

For (employer): _____

Address: _____

_____ _____
Signature Date

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GROUP WEEKLY INDEMNITY BENEFITS CLAIM FORM

ATTENDING PHYSICIAN'S STATEMENT

Patient Name: Age: SSN:

1. Nature of sickness or injury (describe complications, if any)

Is condition due to pregnancy?

2. When did symptoms first appear or accident happen? Date

3. When did patient first consult you for this condition? Date

4. Has patient ever had same or similar condition? (if yes, state when and describe) YES ( ) NO ( )

5. Describe any other disease or infirmity affecting present condition

6. Nature of surgical procedure, if any (describe fully)

7. List dates of treatment ❒ Office ❒ Home ❒ Hospital

8. Is patient still under your care for this condition? YES ( ) NO ( )

If discharged, please give date Date

9. If patient hospitalized, give name and address of hospital:

Name: City: ST : .

Date admitted: Date discharged:

10. How long was or will patient be continuously or totally unable to work?

From: To:

11. Is condition due to injury or sickness arising out of patient's employment? YES ( ) NO ( )

12. Please identify patient's limitations:

13. Remarks:

Physician's Signature Date

Printed Name & Address

Telephone No.:

FOR PROMPT CONSIDERATION, IT IS IMPORTANT THAT ALL QUESTIONS BE FULLY ANSWERED ON BOTH SIDES OF THIS FORM