SHORT-TERM DISABILITY CLAIM FORM

PLANNED ADMINISTRATORS INC

Important Notice to Employee – Please Read Carefully

You or someone acting on your behalf should complete Section 1 and then have your employer complete Section 2. Have your physician complete Section 3 within ten days. After all three sections are completed, submit the form to us at the address or fax number listed below. Your cooperation will facilitate payments promptly when they are due.

Any person who knowingly, and with intent to defraud any insurance company, files a statement of claim containing any false, incomplete or misleading information may be subject to criminal penalties.

SECTION 1: TO BE COMPLETED BY THE EMPLOYEE

Employee Last Name:	Employee First Name:	Middle Initial:	Birthdate (mm/dd/yyyy)

Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Gender: Male ☐ Female ☐

Employee Street Address:	City:	State:	ZIP Code:

Phone Number:	Social Security Number:	Employer Name:

Date you last worked due to your disability (mm/dd/yyyy)	Date you returned to work (mm/dd/yyyy)	If not yet returned, date you expect to return (mm/dd/yyyy)

Disability due to:

☐ Illness

☐ Injury If due to injury, please provide complete details to accident, date, and time (attach a separate sheet if necessary):

I authorize the release to or by Planned Administrators, Inc. (PAI) any medical or insurance information required to process my claim. I understand that any information obtained pursuant to this authorization will be used only to evaluate my claim and may be transferred to any organization or person employed by or representing PAI to assist with this purpose. This authorization is valid for the duration of my claim. I understand I have a right to request and receive a copy of this authorization. A photocopy of this authorization is as valid as the original.

The above statements are true and complete to the best of my knowledge and belief. (Your signature is required for benefit consideration.)

Employee Signature	Date (mm/dd/yyyy)

SECTION 2: TO BE COMPLETED BY THE EMPLOYER

Group Policy No.	Date Employed (mm/dd/yyyy)	Effective Date of Insurance (mm/dd/yyyy)	Occupation/Job Title:	Standard no. of hours worked per week:

Social Security No.	Employee No. (if applicable)	Employee Benefit Class:	Amount of Weekly Benefits:

Date employee last worked: _____ No. of hours: _____ ☐ AM ☐ PM

Date employee scheduled to return to work: _____ ☐ AM ☐ PM

Date employee returned to work: _____ ☐ AM ☐ PM

Employee's wage: $ _____

per ☐ hour ☐ week ☐ year

☐ Hourly ☐ Salaried

Employee status on the last day worked or current employee status:

Comments:

Insured Group Name:	Branch/Division Address:	Phone Number:

Printed Name of Employer Representative:	Title:

Signature of Employer Representative:	Date (mm/dd/yyyy)

Planned Administrators, Inc.
Short-Term Disability Claims
P.O. Box 6927
Columbia, SC 29260
Telephone: 800-768-4375 Fax: 803-870-8788

SECTION 3: TO BE COMPLETED BY PHYSICIAN

Note to Physician:

Completion of this form will assist your patient in presenting claim for group disability benefits. Please complete all areas of the form. If a section is non-applicable, please enter N/A in the response area.

Patient's Last Name:	Patient's First Name:	Middle Initial:	Birthdate (mm/dd/yyyy)

Current Diagnosis:	ICD-9 Code/DSM IV:

Subjective Findings:	Objective Findings:

Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, please specify dates of treatment:

Is disability due to pregnancy? ☐ Yes ☐ No

If yes, LMP (mm/dd/yyyy): _____ EDU (mm/dd/yyyy): _____ Type of delivery: ☐ Vaginal ☐ C-section

Was patient hospitalized? ☐ Yes ☐ No If yes, please provide dates of confinement and name of hospital/facility:	Nature of surgical procedure, if any. (Describe in full.) Date performed (mm/dd/yyyy): _____

TREATMENT

Date the patient first unable to perform job duties (mm/dd/yyyy):	Date of first visit (mm/dd/yyyy)	Date of last visit (mm/dd/yyyy):

Patient's present condition: ☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed	Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other_____

Treatment plan

Functional Impairments	Current medications and dosages

EXTENT OF DISABILITY

Patient released to return to work? ☐ Yes ☐ No

If yes: ☐ Full-time, no restrictions Date return to full duty:

☐ Light duty (Please specify restrictions, limitations, hours, graduated return to work schedule, etc.):

Date return to light duty (mm/dd/yyyy):

Is patient a suitable candidate for a rehabilitation program? ☐ Yes ☐ No

PSYCHIATRIC CONDITION

Is patient competent to endorse checks and direct the proceeds thereof? ☐ Yes ☐ No If no, please attach supporting documentation.

Physician printed last name:	Physician first name:	Middle Initial:	Physician Specialty

Physician street address:	City:	State:	ZIP Code:

Physician phone number:	Physician fax number:	Physician email address:

Signature of physician **X**	Date (mm/dd/yyyy)