PLANNED ADMINISTRATORS INC

P.O. Box 6927
Columbia, SC 29260
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CLAIM FORM FOR GROUP MEDICAL BENEFITS / SHORT-TERM DISABILITY

FOR OFFICE USE ONLY

☐ NEW CLAIM ☐ CONTINUING CLAIM

Claimant should complete the entire form and sign. Be sure all questions are answered. If the question does not apply to your claim, **mark "NA."**

For all expenses claimed, you must attach itemized statements to include: date, type, place of service, charge, and signature of the provider or representative.

PART A: EMPLOYEE STATEMENT

Employee Name:	Employer:	Group #: (see your ID card)
Employee Address:		UMID #: (on front of PAI ID card)

Male ☐ Female ☐	Married ☐ Single ☐ Divorced ☐	Date of Birth:
Active ☐ Retired ☐	Last Date Worked:	Claim on: *(please check one)* Self ☐ Dependent ☐

Patient Name:	Relationship:	Date of Birth:
If full-time student, list name of school:		Annual Salary:

Has this condition been treated in the past? Yes ☐ No ☐	Date First Seen:	Date Last Seen:

Doctor's Name and Address:

Condition:	Please check one: Illness ☐ Injury ☐

If injury, describe how accident occurred:

Please check one: At Work ☐ Home ☐ Auto ☐ Other ☐	Date:

If auto accident, attach traffic report and list below the name of the party responsible for the accident and the auto insurance carrier's name and address.

Are you or your dependents eligible for other benefits under group insurance, Medicare, or any other plan of coverage? Yes ☐ No ☐
If yes, list policy information below.

Name and Address of Insurance Company	*Policy Number*

I hereby certify that the foregoing statements, including any accompanying statements, are true and complete to the best of my knowledge. I hereby authorize any physician, hospital, or organization to release any information to Planned Administrators, Inc. A copy of this authorization shall be valid as the original.

Employee Signature:	Date:

PART B: EMPLOYER STATEMENT *(If this is a short-term disability claim, have your employer complete and sign this statement.)*

Last Date Worked Full-Time:	Date Return to Work Full-Time:	
Signed:	Position:	Date:

PART C: PHYSICIAN STATEMENT (*Have your physician complete and sign this statement.)*

I certify the above claimant was totally disabled from _____ to _____ and was able to return to work full-time on _____.

Conditions/Diagnosis:

Signed:	Date: