



Atlanta Disability Service Center
 P.O. Box 105426
 Atlanta, GA 30348-5426

SHORT TERM DISABILITY CLAIM FORM

Phone: (800) 232-0113
 Fax: (404) 682-9252 or
 (800) 850-0017

E-Mail: disability@wellpoint.com

Important Notice to Employee – Please Read Carefully

You or someone acting on your behalf, must complete Section I and then have your Employer complete Section II. Your physician must then complete Section III on the reverse. After all three sections are completed, please submit the form to us quickly as possible in order for us to make a timely claim decision.

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 I To Be Completed By Employee | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------|
| Name of Employee | <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of Birth: |
| Address of Employee (No. & Street, City, State, Zip) | | Phone No. Other No. Fax No. | |
| E-Mail Address: | | Social Security No. | |
| On what date were you first unable to work because of your disability? (Mo., Day, Yr.) | | | |
| For what injury or sickness are you being treated? | | | |
| If due to accident, when, where and how did it happen? <input type="checkbox"/> Auto <input type="checkbox"/> Worker's Comp <input type="checkbox"/> Home <input type="checkbox"/> Other | | | |
| Date you returned to work?(Mo., Day, Yr.) | | Name of Employer: | |
| If not yet returned, when do you expect to? (Mo., Day, Yr.) | | | |
| <i>I authorize the release to or by Greater Georgia Life Insurance Company any medical or insurance information required to process my claim. A photocopy of this authorization may be honored.</i> | | | |
| EMPLOYEE'S SIGNATURE: _____ | | | Date: _____ |
| Section II To Be Completed By Employer | | | |
| Name of Employee: | | Group Policy No.: | |
| Date Employed: | | Effective Date of Insurance: | |
| Weekly or Hourly Wage at the time disability occurred: | | Occupation/Job Title: | |
| Employee Class: | | Amount of Weekly Benefits: | |
| Date Employee Last Worked & Number of hours? <input type="checkbox"/> AM <input type="checkbox"/> PM | | Date Employee Returned to Work? <input type="checkbox"/> AM <input type="checkbox"/> PM | |
| Did injury or sickness arise out of or in the course of occupational employment for wages or profit? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Comments: | | | |
| Insured Group Name: | | Branch or Division Address: | |
| Signature and Title: | | Phone No.: | Date: |

Section III To Be Completed By Physician**Note to Physician:****Completion of this form will assist your patient in presenting claim for group and/or individual disability benefits.**

| | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|-------------------------------------------------------|
| Patient's Name: | | Date of Birth: |
| Current Diagnosis: | ICD-9 code/DSM IV: | |
| Subjective Findings: | Objective Findings: | |
| Has patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, specify dates of treatment: | | |
| Is condition due to injury or sickness arising out of patient's employment? (if "Yes", please explain) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | |
| Is Disability Due to Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No | If Yes, LMP: ___/___/___ (Mo., Day, Yr.) | EDC: ___/___/___ (Mo., Day, Yr.) |
| Nature of surgical or obstetrical procedure, if any. (Describe fully) <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient | | Date Performed: ___/___/___ (Mo., Day, Yr.) |
| Was the patient hospitalized? If so, give date(s) of confinement and name of hospital/facility: | | |

Treatment

| | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|
| Date patient first became unable to perform job duties: | |
| Date of first visit: | Date of last visit: |
| Patient's present condition: <input type="checkbox"/> Recovered <input type="checkbox"/> Improved <input type="checkbox"/> Unchanged <input type="checkbox"/> Regressed | Treatment plan: |
| Functional impairments: | Current medications & dosages: |

Extent of Disability

| | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| Patient may return to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> Full Time, No Restrictions <input type="checkbox"/> Light Duty (Please specify restrictions, limitations, hours, graduated return to work schedule, etc.) | Date Return to Full Duty: ___/___/___ Date Return to Light Duty: ___/___/___ |
| Is patient a suitable candidate for rehabilitation program? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Psychiatric Condition

| | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|
| Is the patient competent to endorse checks and direct the proceeds thereof? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please attach supporting documentation. | |
| Physician's Name and Specialty (Please Print): | |
| Physician's Signature: ▶ | Date: |
| Physician's Address (No. & Street, City, State, Zip): | Telephone No.: E-Mail Address: Fax No.: |