SECUREONE℠
Benefit Administrators, Inc.

Mail To: SecureOne Benefit Administrators, Inc.
P.O. Box N
Grand Rapids, MI 49501-4914

Fax To: (616) 454-4338

DISABILITY CLAIM

PART 1 – EMPLOYEE STATEMENT

THE COMPANY I WORK FOR IS:

EMPLOYEE'S NAME

DATE OF BIRTH		SOCIAL SECURITY NO.
☐☐/☐☐/☐☐	☐ SINGLE ☐ DIVORCED ☐ MARRIED ☐ WIDOWED	☐☐☐-☐☐-☐☐☐☐

STREEET ADDRESS | CITY or TOWN | STATE | ZIP CODE

WHAT IS THE NATURE OF ILLNESS FOR THIS DISABILITY

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any insurance company, prepayment organization, employer, hospital or physician to release all information with respect to myself, which may have a bearing on the benefits payable under this, or any other plan providing benefits or service. A PHOTOCOPY OF THIS AUTHORIZATION WILL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

_____ _____
SIGNED (insured Employee) DATE

PART 2 – ATTENDING PHYSICIAN'S STATEMENT

1. PATIENT'S NAME

2. DIAGNOSIS AND CONCURRENT CONDITIONS (If diagnosis code other than ICDA* used, give name)

3. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? ☐ YES ☐ NO

PREGNANCY? ☐ YES ☐ NO If yes, approximate date pregnancy commenced. DATE

4. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED	5. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION.
6. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITIONS? ☐ YES ☐ NO If "yes" list when and describe:	7. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO

PART 2B - ATTENDING PHYSICIAN'S STATEMENT REGARDING DISABILITY

8. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (Unable to Work). From Thru	9. PATIENT WAS PARTIALLY DISABLED. From Thru
10. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK.	11. PATIENT WAS HOUSE CONFINED. From Thru

Under Section 6109 of the Internal Revenue code, recipients of medical and health care payments are required to furnish identifying numbers to payers who must report such payments to the Internal Revenue Service.

SSN ☐☐☐ - ☐☐ - ☐☐☐☐ **E.I.N.** ☐☐ - ☐☐☐☐☐☐☐

DATE PHYSICIAN'S NAME (Print) SIGNATURE DEGREE TELEPHONE

STREET ADDRESS | CITY or TOWN | STATE | ZIP CODE

PART 3 – FOR EMPLOYER TO COMPLETE (PLEASE PRINT)

1. Employer's Name and Address

2. Employee's Name	3. Date of Birth	4. Social Security Number
	☐☐/☐☐/☐☐	☐☐☐-☐☐-☐☐☐☐

5. Date of Hire	6. Effective Date of Insurance	7. Occupation at time last worked	8. Employee's work schedule
			☐ Full Time ☐ Exempt ☐ Part Time ☐ Non-Exempt Regularly scheduled hours per week_____

9. How was employee paid? (Please check one)

☐ Hourly ☐ Salary and bonus
☐ Commissions ☐ Commissions Only
☐ Salaried ☐ Salary and Commissions

10. Salary prior to date last worked: (refer to earnings definition in your contract)

Basic weekly wages $_____ Commissions $_____
W-2 Earnings $_____ Bonus $_____
Overtime $_____

11. Date of last salary increase

12. Employee's work schedule at time last worked.

_____ Days per week

_____ Hours per week

12a. Date last worked _____ 12b. Number of hours worked that day _____

12c. Date paid through _____ For: ☐ Salary continuation ☐ Vacation pay ☐ Accrued sick pay

13. Has employee returned back to work? If yes, date Full Time _____ Part Time _____

DATE EMPLOYEE LAST WORKED	REASON FOR LEAVING	DATE RETURNED TO WORK	OCCUPATION	IS PATIENT ENTITLED TO WORKERS' COMPENSATION FOR THIS CLAIM ☐ YES ☐ NO

14. Are you as the employer able to accommodate the employee's restrictions and limitations, if appropriate, for an early return to work? (i.e. job modification, part time, etc.) Please elaborate.

15. Does employee contribute toward the premium? ☐ Yes ☐ No

If Yes, ☐ Pre Tax or ☐ Post Tax If Post Tax: _____% paid by employer _____% paid by employee

If you leave this section blank, we will assume it is 100% employer contribution and calculate FICA taxes accordingly.
Please call 1-800-845-2290 for tax related questions.

16. Is employee eligible for:	Yes	No	If yes, weekly or monthly amount	WEEKLY	MONTHLY	Provider of Carrier Name and Address	Date Benefits Begin Date	Through Date
Salary Continuation	☐	☐	$_____	☐	☐	_____	____/____/____	____/____/____
Other Disability Benefits	☐	☐	$_____	☐	☐	_____	____/____/____	____/____/____
Disability Pension	☐	☐	$_____	☐	☐	_____	____/____/____	____/____/____
Retirement Pension	☐	☐	$_____	☐	☐	_____	____/____/____	____/____/____
State Disability	☐	☐	$_____	☐	☐	_____	____/____/____	____/____/____
Auto No Fault	☐	☐	$_____	☐	☐	_____	____/____/____	____/____/____
Social Security	☐	☐	$_____	☐	☐	_____	____/____/____	____/____/____
Other Benefits	☐	☐	$_____	☐	☐	_____	____/____/____	____/____/____
Workers' Compensation	☐	☐	$_____	☐	☐	_____	____/____/____	____/____/____
Has Workers' Compensation claim been filed?	☐	☐	If a Workers' Compensation claim had been denied, please submit a copy of the denial with this claim.					

17. Will (or has) the employee filed for disability benefits by any employer, employee, labor management, state disability or union welfare plan? ☐ Yes ☐ No

If yes, Weekly Amount $_____ Date Began _____

18a. Policy Number-Short Term Disability	19. Policy Number – Long Term Disability	20. Employer's Taxpayer ID Number (EIN) or Public Employer Social Security Number. If you have neither, please explain.
18b. Policy Division / 18c. Policy Class	Is this employee enrolled in your Long Term Disability Plan? ☐ Yes ☐ No	

Signature of Authorized Person

X Area Code ☐☐☐-☐☐☐-☐☐☐☐

Print or Type Name Title

Area Code ☐☐☐-☐☐☐-☐☐☐☐

Signature (The above statements are true and complete to the best of my knowledge) Date