Disability Claim Form

INSTRUCTIONS:

On this page: fill in name, address, ID#, birth date, telephone number and your employer's name and address. In the "Disability Information" section, complete all requested information. Sign and date the "Employee Certification" section.

On page 2: have your doctor complete the "Doctor's Statement".

Submit completed form to: Significa Benefit Services, Inc.
P. O. Box 7777
Lancaster, PA 17604-7777
For secure submission of claims with PHI, go to:
www.significabenefits.com\members
select "Submit Secure Email or Attachment"
Fax (717) 581-8379

COMPLETE FOR DISABILITY CLAIM PLEASE PRINT

Employee Name: ____

Home Address: ____

____

Member ID #:____________________ Date of Birth: ____________________

Daytime Telephone: (____) ______ - __________

Employer's Name and Address: ____

____

DISABILITY INFORMATION (Attach additional information if necessary)

1) Occupation (List duties at time of disability)			
2) Date of accident or date sickness began:	3) Date you first were unable to work:	4) Date you returned to work on a part-time basis:	5) Date you returned to work on a full time basis:
6) Is your accident or illness job related: ☐ Yes ☐ No	7) If question 6 is "Yes" explain: Have you or are you going to file a Worker's Comp. Claim? ☐ Yes ☐ No		
8) Describe how and where the accident occurred or describe the nature of your illness:			
9) Date first treated for your illness or injury:	10) Treated by: Name and Address Hospital______________________ ______________________ Doctor______________________ ______________________		
11) Have you ever had the same or similar condition in the past? ☐ Yes ☐ No	12) If question 11 is "Yes" - Treated by: Name and Address Hospital______________________ ______________________ Doctor______________________ ______________________		

EMPLOYEE CERTIFICATION AND AUTHORIZATION

I authorize the release of any information about this claim and certify that the information is complete and correct. I understand if I knowingly and with intent to defraud you or any person, file a statement of claim containing any materially false information, or conceal for the purpose of misleading information concerning any fact material thereto, ***I commit a fraudulent insurance act, which is a crime and is subject to criminal and civil penalties.***

Employee Signature:______________________________Date: ____________________

DOCTOR'S STATEMENT (Attach Medical Summaries or Records to help identify problem-causing disability.)

1. Date symptoms first appeared or accident happened:______________________________
2. Date patient stopped work due to disability: ______________________________
3. Has patient ever had similar conditions? ☐ Yes ☐ No If "yes", describe
____
4. Is condition work related: ☐ Yes ☐ No Is it a pregnancy? ☐ Yes ☐ No
If "yes", due date:______/______/ ______
5. Diagnosis or Nature of illness or injury. ______________________________
____
(If Diagnosis Code used is other then ICDA* then give name)
6. Objective Findings (including current x-rays, EKG's, Laboratory data and any clinical findings.)
____
____
7. Date of first visit:____________________Date of last visit ____________________
Frequency: ☐ Weekly ☐ Monthly ☐ Other ____________________________
8. Course of Treatment - Type and Frequency. If on Medication, list type, dosage and frequency.
____
9. Describe physical limitations and how they prevent employment. If progressive, describe progression in detail and last specific changes causing inability to work______________________________
____
10. Has patient: ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed
11. Is Patient:
☐ Hospital Confined ☐ Bed Confined ☐ House Confined ☐ Ambulatory
12. Patient was/will be continuously disabled (unable to work) – (dates)
from:__________________________to: __________________________
13. Patient was/will be partially disabled - (dates)
from:__________________________to: __________________________
14. Is Patient still under your care for condition? ☐ Yes ☐ No
If still disabled, date to return to work: ______________________________

If previous form was submitted, show dates and service since last report. Report all dates of services starting with the first visit to last visit.

Date of Services	Place of Services	Description of Surgical or Medical Services Rendered	Procedure Code

Codes: (if other than Current Procedural Terminology, give name) O=Doctor's Office IH=Inpatient Hospital NH=Nursing Home
H=Patient's Home OH=Outpatient Hospital OL=Other Location *ICDA-Inter. Classification of Diseases

Physician's Name (Print or Type):______________________________Date: ____________

Physicians' Signature:____________________________________Date: ____________

Federal Tax ID Number (required): ____________________________________

Telephone Number: ____

THE INFORMATION DISCLOSED ON THIS FORM IS PROTECTED HEALTH INFORMATION WHICH IS PRIVILEGED AND CONFIDENTIAL. THIS INFORMATION WILL NOT BE USED OR DISCLOSED EXCEPT AS PERMITTED OR REQUIRED BY LAW.