UNICARE®

Short Term Disability Claim Statement

1-800-232-0113
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P.O. Box 723058
Atlanta, GA 31139-0058

Important Notice to Employee – Please Read Carefully

You or someone acting for you should fill out Section I below, and have your doctor fill out Section III on the reverse side. This form should be completed by your doctor within ten days, and returned to your employer. 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 I To Be Completed By Employee

1	Name of Employee	☐Married ☐ Widowed ☐Single ☐ Divorced	Sex ☐ Male ☐ Female	Date of Birth
2	Address of Employee (No. & Street, City, State, Zip)		Phone No. Other No. Fax No.	
3	E-Mail Address:		Social Security No.	
4	On what date were you first unable to work because of your disability? (Mo., Day, Yr.)			
5	For what injury or sickness are you being treated?			
6	If due to accident, when, where and how did it happen? ☐ Auto ☐ Worker's Comp ☐ Home ☐ Other			
7	Date you returned to work (Mo., Day, Yr.)	Name of Employer		
8	If not yet returned, when do you expect to? (Mo., Day, Yr.)			

I authorize the release to or by UNICARE Life & Health Insurance Company of any medical or insurance information required to process my claim. A photocopy of this authorization may be honored.

EMPLOYEE'S SIGNATURE **Date**

Section II To Be Completed By Employer

1	Name of Employee	Group Policy No..
2	Date Employed	Effective Date of Insurance
3	Monthly or Hourly Wage at the time disability occurred	Occupation
4	Employee Class	Amount of Weekly Benefits
	Date Employee Last Worked & Number of hours? ☐ AM ☐ PM	Date Employee Returned to Work? ☐ AM ☐ PM
	Did injury or sickness arise out of or in the course of occupational employment for wages or profit? ☐ Yes ☐ No	
	Comments:	

Policyholder	Branch or Division Address & Phone No.	
Signature and Title ▸	Phone Number	Date

Section III To Be Completed By Physician

Note to Physician:
Completion of this form will assist your patient in presenting claim for group disability benefits.

1	Patient's Name	Age
2	Current Diagnosis	ICD-9 code/DSM IV
	Subjective Findings	Objective Findings
3	Has patient ever had same or similar condition? ☐ Yes ☐ No If so, specify dates of treatment:	
4	Is condition due to injury or sickness arising out of patient's employment?(if "Yes", please explain) ☐ Yes ☐ No ☐ Unknown	
	Is Disability Due to Pregnancy? ☐ Yes ☐ No	If Yes, LMP: ___/___/___ (Mo., Day, Yr.) EDC: ___/___/___ (Mo., Day, Yr.)
5	Nature of surgical or obstetrical procedure, if any. (Describe fully) ☐ Inpatient ☐ Outpatient	Date Performed ___/___/___ (Mo., Day, Yr.)
	Was the patient hospitalized? If so, give date(s) of confinement and name of hospital/facility	
6	Treatment	
	a) Date patient first became unable to perform job duties	
	b) Date of first visit / /	Date of last visit / /
	c) Frequency of visits ☐ Weekly ☐ Monthly ☐ Other	
7	a) Patient's present condition ☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed	b) Treatment plan
	b) Functional impairments	d) Current medications & dosages
8	Extent of Disability	
	a) Patient may return to work? ☐ Yes ☐ No If yes, ☐ Full Time, No Restrictions ☐ Light Duty (Please specify restrictions, limitations, hours, graduated return to work schedule, etc.) b) Is patient a suitable candidate for rehabilitation program? ☐ Yes ☐ No	Date Return to Full Duty: ___/___/___ Date Return to Light Duty: ___/___/___
9	Psychiatric Condition	
	a) Is the patient competent to endorse checks and direct the proceeds thereof? ☐ Yes ☐ No b) 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 Number: E-Mail Address: Fax Number: