MEDMUTUAL PROTECT®
A Medical Mutual® Company

INSURANCE BENEFITS PROVIDED BY
RESERVE NATIONAL INSURANCE COMPANY

P.O. Box 14327, Reading, PA 19612
Telephone: 855.521.9345 Fax: 610.374.6986
Portal: https://medmutualprotect.loomislive.com

SHORT-TERM DISABILITY CLAIM FORM

INSTRUCTIONS:

1. Participant must complete **PART I**.
2. Take form to your physician for completion of **PART II**. Return form to your employer for completion of **PART III**.
3. Completed form (includes PART I – PART III) must be forwarded to the above address or fax number.
4. Do not complete the claim form until your disability start date.
5. If the disability is from a car accident, please provide a copy of the police report.
6. Please contact our Customer Service Department once you return to work so that your claim does not become overpaid.

PART I – EMPLOYEE'S STATEMENT

1. Full name of participant (please print)	2. Group Number	3. Date of birth
4. Employee's full address	5. Occupation	6. Social Security No.

7. Nature of sickness or injury

8. Sickness Have you ever been sick with this condition before? ☐ Yes ☐ No Date you first noticed sickness: _____	9. Date of first medical treatment for this condition: _____ Treatment received: _____	10. If pregnancy, indicate conception and/or delivery date. a. Conception: _____ b. Delivery: _____

11. Injury: _____ Date of injury: Place: _____	12. Date on which you were first unable to work:

13. How did injury happen?

14. Have you engaged in any work, part-time or otherwise, since your sickness or injury began? If yes, please explain and give dates.

15. If you have recovered or returned to work, give date:	16. If still totally disabled, when do you expect to return to work?

17. Names and addresses of all physicians who have been consulted because of this condition:

Name	Address	Dates of treatment or consultation

18. Have you been confined to a hospital for this disability? ☐ Yes ☐ No If yes, please complete the information below.

Name of Hospital	Address	From	Through

AUTHORIZATION

I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICAN OR OTHER PROVIDER, INSURER OR OTHER THIRD-PARTY PAYER OR THE MEDICAL INFORMATION BUREAU TO FURNISH TO RESERVE NATIONAL INSURANCE COMPANY, OKLAHOMA CITY, OKLAHOMA, OR ITS REPRESENTATIVE, OR PERMIT SAID INSURANCE COMPANY, OR ITS REPRESENTATIVE, TO REVIEW ANY INFORMATION REQUESTED WITH RESPECT TO ANY ILLNESS OR ACCIDENT, MEDICAL HISTORY OR COPIES OF HOSPITAL AND MEDICAL RECORDS. THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION ABOUT COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE BUT ARE NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, HUMAN IMMUNODEFICIENCY VIRUS, AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). A PHOTOSTATIC COPY OF THE AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINIAL. I DECLARE THE ABOVE ANSWERS AND STATEMENTS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Date _____ Signature of Participant _____

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PART II – PHYSICIAN STATEMENT (Must be completed by physician)

1. Diagnosis and concurrent conditions (if diagnosis code other than ICD-9 used, please give name):	2. Surgeries Performed/Date of Surgery:
3. Is condition a result of an accident or illness? ☐ Accident ☐ Illness (check one)	
4. Is condition due to injury or sickness arising out of: a. Patient's employment? ☐ Yes ☐ No b. Pregnancy? ☐ Yes ☐ No If pregnancy, please give estimated Delivery date: _____ Type of delivery: _____	
5. Initial date of treatment:	6. Last date of treatment:
7. Date symptoms first appeared or accident happened:	8. Date patient first consulted you for this condition:
9. Patient ever had same or similar condition? ☐ Yes ☐ No If yes, when and describe:	10. Patient still under your care for this condition? ☐ Yes ☐ No
11. Dates of services since disability commenced:	12. Please indicate if any diagnostic tests:
13. Patient was continuously totally disabled (unable to work): From_____ To _____ Partially disabled: From_____ To_____	14. If still disabled, date patient should be able to return to work:

Physical Impairments (As defined in Federal Dictionary of Occupational Titles)
☐ Class 1- No limitation of functional capacity, capable of heavy work. No restrictions. (0-10%)
☐ Class 2-Medium manual activity. (15-30%)
☐ Class 3-Slight limitation of functional capacity; capable of light work activity (35-55%)
☐ Class 4-Moderate limitation of functional capacity; capable of clerical/administrative (sedentary, activity (60-70%)
☐ Class 5- Severe limitation of functional capacity; incapable of minimum (sedentary) activity (75-100%)

Comments/Restrictions:

Physician's Name:	Date:
Address:	
Phone Number:	Fax Number:
Date:	By (authorized signature):

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PART III – EMPLOYER'S STATEMENT (Must be completed by employer)

Full Name of Participant (please print)	Date Employed:	Effective Date of Coverage (under this plan)

Social Security No.	Weekly Salary Amount $_____	Annual Salary Amount $_____	Average hours worked per week:

Status of employment at the time of disability: ☐ Full-time ☐ Part-time ☐ Leave of Absence ☐ Terminated ☐ Retired

Date: _____ To: _____

Occupation, position, or title:	Job classification: ☐ Sedentary ☐ Light ☐ Medium ☐ Heavy ☐ Very Heavy

Describe the participant's job duties or attach a formal job description. Please be specific.

Date last worked:	Date disability began:	Has participant returned to work? ☐ Yes ☐ No Date of Return _____ Full-time_____ Part-time_____

Did this disability arise out of, or in the course of, any employment of the participant's?

☐ Yes ☐ No If yes, please explain: _____

Is there any possibility for Workmen's Compensation liability for this claim? ☐ Yes ☐ No

Weekly benefit: $ _____

Does employee participate in Social Security? Yes or No If no, hired after 4/1/86? ☐ Yes or ☐ No

Is the disability premium paid by the employee/insured person? ☐ Yes ☐ No If "Yes", ☐ Before or ☐ After

Name, address and phone number of any other disability carrier: (include street, city, state and zip code)

Employer's/Business Entity's Authorized Representative

Name (please print)_____Title_____Phone_____

Employer's Address:

Phone Number: Fax Number:

Date: Employer's Signature: