SHORT TERM DISABILITY FOLLOW UP STATEMENT

Complete Part I and have your Physician complete Part II. Return to:
Manatt's Inc., Attn: Diane Kilmer, PO Box 535, Brooklyn, IA 52211 FAX: 641-522-5090 or E-MAIL: dianek@manatts.com.

PART I – EMPLOYEE'S STATEMENT

I hereby apply for benefits due me on account of sickness or injury which has caused me to be continuously unable to work since _____, 20 _____.

Print full name _____ Sex _____ Date of Birth _____ SSN _____

Residence address _____ City _____ State _____ Zip _____

Name of doctor first consulted _____ Date of first visit _____

Last day able to work _____ Date of return (or expected return to work)_____

PART II – PHYSICIAN'S STATEMENT

Patient Name _____

Nature and cause of disability _____Diagnosis_____

Did sickness or injury arise out of patient's employment? Yes_____ No _____
Due to pregnancy? Yes _____ No _____ Expected delivery date _____

Date first treated _____ Date symptoms first appeared or accident happened _____

Has patient been disabled soley by this injury or sickness as to be unable to work? Yes _____ No _____
If so, for how long? From _____, 20 ____ Through _____, 20 ____, Inclusive

If still disabled, when do you expect the employee will be able to return to work? _____

Date of all visits At my office _____
_____
At patient's home _____
_____
At hospital _____
_____

If patient was hospitalized, give dates. From _____ To _____

Name of any operation performed _____ Date of any operation _____

Is patient still under your care for this condition? Yes _____ No _____ If No, give discharge date _____

_____ _____
Print Physician's Name Physician's Signature Date

_____ _____
Street Address Physician's Phone

_____
City State Zip