SHORT TERM DISABILITY CLAIM FORM

Complete Part I and have your Physician complete Part III. Return via USPS to Manatts, Inc., Attn: Diane Kilmer, PO Box 535, Brooklyn, IA 52211, fax (641).522.5090 or email dianek@manatts.com .

PART 1 – 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 _____

Does ailment result from your occupation? Yes _____ No _____ When did sickness/injury begin? _____

Cause of disability (Describe sickness or injuries)

_____

_____

If hospitalized, give date admitted _____ and date discharged _____

If due to an accident, how did it occur? _____
Where _____ Date _____ AM _____ PM _____

Name of doctor first consulted _____ Date of first visit _____

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

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION
I authorize any physician, dentist, medical practitioner, hospital, or clinic to provide to Manatt's Inc., or its representative, any information regarding medical history, symptoms, treatment, examination results, or diagnosis pertaining to this claim.

_____ _____ _____
Employee Signature Date Phone Number

PART II – EMPLOYER'S STATEMENT

Employee Name _____ SSN _____

Was claimant employed and eligible for insurance when disability began? Yes _____ No _____

Did injury or illness arise out of occupation? Yes _____ No _____
If Yes, is this disability being reported to the state or any insurance company as a Worker's Compensation Claim? Yes _____ No _____

List amount of weekly compensation payment _____ Last day worked or able to work _____

_____ _____
Employer's Signature – Title Date

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PART III – 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 Number

_____
City

_____
State Zip