SHORT TERM DISABILITY CLAIM FORM

Interactive Medical Systems, PO Box 1349, Wake Forest, NC 27588

STATEMENT OF EMPLOYEE

Social Security # ___________________ Occupation _______________________

Last Name _______________________ First Name _______________________

Address ____

Is disability due to _____ sickness or _____ accident Describe ____

____

Is disability due to employment _____ If yes, describe ____

____

____

Do you have disability coverage with any other companies _____ If yes, describe ________________________________

____

By signing below, you are authorizing the release of any information to Interactive Medical Systems (IMS) and certifying the information provided in support of this claim is complete and correct. By signing the statement, the employee consents to the use and disclosure of information relating to the services provided by the health care professional for the purpose of treatment, payment, or health care operation, including submission of a claim for benefits to a provider or administrator.

Signature ____ **Date** ______________

STATEMENT OF EMPLOYER

Employee Social Security # __________ Last Name ____

First Name _______________________ Address ____

City _________________________ State _____________________ Zip Code________________

Phone _________________________ E-Mail Address _______________________________________

Gender ___________________ Birth Date ______________________ Hire Date ________________________

Salary Weekly $_____________ Monthly $________________

First Date Unable to Work ___________ Was it a full day _____Yes _____ No If no, # of hours worked ______

Date Employee is Expected/Did Return __________________________ Return to work date unknown ________

Occupation and description of Work Activities ____

____

____

Work Related ___ No ___ Yes If yes, explain ____

Is employee eligible for Disability Income Benefits under any Compulsory Benefit Law? _______ No _______ Yes

If yes, explain ____

In your opinion, are employee activities consistent with your Plan's definition of disability. _______ No _______ Yes

Explain: ____

Company Name ____________________ **Signature** __________________________________ **Date** ________

ATTENDING PHYSICIAN STATEMENT

PATIENT NAME	DIAGNOSIS PRIMARY	DIAGNOSIS SECONDARY

Date patient first consulted you for this condition ______________________________

What Medically and/or Functionally limits this patient from performing their job ______________________________
____
____

Treatment plan ______________________________
____
____

Progress and present status ______________________________

Is condition work related _______ No _______ Yes

If pregnancy, expected due date ____________________ Delivery type Vaginal ________ C-Section ________

Is/was patient hospitalized for this disability ___________ No ______________Yes Dates ______________________

Has surgery been scheduled ____ No ____ Yes Date and procedure ______________________________

Is patient incapable of performing all parts of their usual work ______________________________

If not, is patient able to perform any other work _________ No _________ Yes From date ________ Thru date ________
List specific restrictions ______________________________

If still disabled, when is your opinion will patient be able to return to work ______________________________

If not still disabled, when was patient released to return to work ______________________________

Physician Printed Name ______________________________ Specialty ______________________________

Physician Signature ______________________________ Date ______________________________

Phone #: ______________________________ Tax ID# ______________________________

Address ______________________________

The Genetic Information Non-Discrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply, we are asking that you not provide genetic information when responding to this request for medical information. Genetic information includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual's family member sought or received genetic services, and genetic information on a fetus carried by an individual's family member, or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Interactive Medical Systems, Claims Department, Fax# 919-562-0021, Phone# 919-877-9933 ext. 5050