Employee's Short Term Disability Claim Report

GE Financial Assurance
Employer Services Group

GE Group Life Assurance Company
100 Bright Meadow Boulevard
P.O. Box 1955
Enfield, CT 06083-1955

Must Be Completed in Full at No Expense to GE Group Life Assurance Company

Employer's Statement

Name of Employee (Last, First, M.I.)

Social Security Number — —

Group Policy Number

Employment Effective Date

Employee's Insurance Effective Date

Date Last Actively Worked

Reason For Leaving Work

Occupation

☐ Union Employee ☐ Paid Hourly / Rate___________
☐ Non-Union Employee ☐ Paid Salary

Basic Weekly Hours Worked

Days Worked - Please Check
☐ Sun ☐ Mon ☐ Tues ☐ Wed
☐ Thurs ☐ Fri ☐ Sat

Basic Weekly Earnings

Date Of Last Salary Change

Insurance Class

This Employee Is Eligible For Salary Continuation
Amount ___________ Duration ___________

Short Term Disability Amount

Is employee's disability due to injury or sickness caused by insured's current or prior employment? ☐ Yes ☐ No
If "yes" and the Workers' Compensation carrier has denied, please provide us with a copy of the denial letter.

Has employee returned to work? ☐ Yes ☐ No (If "yes", give date returned) Full-time ______________________ Part-time __________________

Does employee contribute towards the cost of this insurance? ☐ Yes ☐ No If yes, __________% paid by employee.
If the previous question is left blank, we will assume the employer pays 100%. Employee contributions were made on: ☐ Pre-tax Basis ☐ Post-tax Basis

Name of Employer

Telephone Number
( )

Employer's Address (No., Street, City, State, ZIP Code)

Signature of Administrator

Title

Date Signed

Employee's Statement

Name Of Employee (Last, First, M.I.) - Please Print

Telephone Number
( )

Social Security Number — —

Employee's Address (No., Street, City, State, ZIP Code)

Sex
☐ Male ☐ Female

Date Of Birth
/ /

Marital Status
☐ Married ☐ Single ☐ Widowed

Is Spouse Employed?
☐ Yes ☐ No

Spouse's Date Of Birth
/ /

Date You Last Worked Prior To Disability

Date Returned To Work (with any employer)

Were You Hospital Confined? (If "yes", give dates)
☐ Yes ☐ No From ________/_____/_____ To ________/_____/_____

If disability is due to an accident or injury, please explain how, when and where it occurred.

Do you believe this disability was caused by your current or prior occupation or employment? ☐ Yes ☐ No
If related to prior or other employment. Please indicate name of employer: ___________________________

Are you now receiving or have you applied for workers' compensation benefits? ☐ Yes ☐ No If yes, amount $______________________

Are you entitled to, filed for, or receiving social security disability, social security retirement or any alternate benefit such as railroad retirement or state or county retirement? ☐ Yes ☐ No If "receiving", indicate amount $____________________and attach award letter

Are you entitled to or have you applied for any state cash sickness benefits? ☐ Yes ☐ No If "yes", indicate amount $_____________________________

Signature of Employee - I certify that the foregoing statements are true to the best of my knowledge.

Date Signed

I hereby authorize any physician, medical practitioner, hospital, clinic, pharmacy or other medically related facility or provider of medical services, and any employer, group policyholder, contract holder, insurer or government agency to release to GE Group Life Assurance Company or its representatives, any and all information you may have about my mental and physical history, prescriptions, care and treatment (including drug and/or alcohol abuse information); HIV-related, AIDS or AIDS-related information to the extent permitted by law; employment information and insurance coverage or benefit information.

I understand that the information released under this authorization will be used for the purpose of evaluating a claim for benefits.

I agree that this authorization shall be valid for the duration of my claim or the time period permitted by jurisdictional law.

A photocopy of this authorization shall be as valid as the original. I know that I have a right to request and receive a copy of this authorization.

Signature____ Date Signed ______________________

State law, in some states, requires the following statement: A person commits a fraudulent insurance act, which is a crime, if he or she knowingly and with intent to defraud any insurance company or other person, either: (1) Files a statement of Claim that contains any materially false information; or (2) Conceals for the purpose of misleading, information about any fact that is material to a claim. **VIOLATIONS ARE SUBJECT TO CRIMINAL PROSECUTION AND MAY ALSO RESULT IN SUBSTANTIAL CIVIL PENALTIES.**

Continued on Reverse

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Attending Physician's Statement

Name of Patient (Last, First, M.I.) - Please Print			Date of Birth / /
Diagnosis			ICD - 9 Code
Symptoms			
Date of First Treatment for this Disability	Date of Most Recent Treatment	Frequency of Treatment ☐ Weekly ☐ Monthly ☐ Other______	Date of Next Appointment

Disability is Due To

☐ Sickness ☐ Accident/Injury If accident, explain how, when & where it occurred.

Is the disability due to injury or sickness caused by patient's current or prior employment? ☐ Yes ☐ No

Is the patient competent to endorse checks and direct the use of the proceeds thereof? ☐ Yes ☐ No

If disability is due to pregnancy, please provide the following
L.M.P: ________ Expected Date of Delivery ________ Actual Date of Delivery ________ Type: ☐ Normal ☐ C-Section

Name of Surgical or Obstetrical Procedure (Describe fully,and provide dates if any)

If any of the following questions are answered "Yes", then please provide the information to the right of that question.

Question			
Was the patient treated in an emergency room? ☐ Yes ☐ No	Date Treated in Emergency Room / /	Hospital	Physician
Was the patient treated by another physician? ☐ Yes ☐ No	Date Treated By Another Physician	Physician	
Was the patient hospital confined? ☐ Yes ☐ No	Dates Confined in Hospital From ___/___/___ To ___/___/___		Hospital
Did patient have outpatient surgery in a hospital or ambulatory surgical center? ☐ Yes ☐ No	Date of Surgery / /	Name of Facility	

Physical Impairment

- ☐ Class 1 - No Limitation of functional capacity, capable of heavy work. No restrictions.
- ☐ Class 2 - Medium manual activity.
- ☐ Class 3 - Slight limitation of functional capacity, capable of light work.
- ☐ Class 4 - Moderate limitation of functional capacity, capable of clerical/administrative (sedentary) activity.
- ☐ Class 5 - Severe limitation of functional capacity, incapable of minimum (sedentary) activity.

Cardiac

Functional Capacity (American Heart Association)
☐ Class 1 - No Limitation ☐ Class 2 - Slight limitation ☐ Class 3 - Marked limitation ☐ Class 4 - Complete limitation

Functional Limitations - Abilities

Indicate frequency per day the listed activity can be preformed.
(N - Never, O - Occasional, F - Frequent, C - Constant)

LIFTING	CARRYING
______ 1-5 lbs.	______ 1-5 lbs.
______ 6-10 lbs.	______ 6-10 lbs.
______ 11-25 lbs.	______ 11-25 lbs.
______ 26-50 lbs.	______ 26-50 lbs.
______ 51-100 lbs.	______ 51-100 lbs.
______ Over 100 lbs.	______ Over 100 lbs.

Indicate longest single time duration each activity can be preformed.

_____ Sitting	_____ Kneeling	_____ R Finger Dexterity
_____ Total time on feet		_____ L
_____ Standing	_____ Inside	_____ R Below Shoulders (Reaching)
_____ Walking		_____ L (Reaching)
_____ Bending	_____ Outside	_____ R Above Shoulders (Reaching)
_____ Squatting	_____ Working with Others	_____ L (Reaching)
_____ Stooping	_____ Other (explain) ________	

Psychiatric Impairment (if applicable)

- ☐ Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations).
- ☐ Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations).
- ☐ Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations).
- ☐ Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations).
- ☐ Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations).

The patient has been continuously disabled (unable to work) from ________ to ________

The patient should be able to work ☐ full-time ☐ part-time on (date) ________ or in ☐ 1 mth ☐ 1-3 mths ☐ 3-6 mths ☐ Other ________

Remarks

Name of Attending Physician - Please Print	Tax Identification Number
Address (No. Street, City, State, ZIP Code)	Telephone Number ( )
Signature of Attending Physician	Date Signed