



Short Term Disability Supplementary Claim Report

GE Financial Assurance
Employer Services Group

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

Form must be completed in full at no expense to GE Group Life Assurance Company.

Employee Statement

Name of Employer		Group Policy Number
Name of Employee (Last, First, M.I.) - Please Print	Social Security Number / /	Telephone Number ()
Address of Employee (No. and Street, City, State, Zip Code)		
Are you now receiving or have you filed for: Social Security Retirement or Social Security Disability Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Workers' Compensation Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, amount \$_____ If yes, amount \$_____ Date of Award _____		
Are you able to work for this or any other employer? (If "yes", give date returned to work) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Full-Time _____ <input type="checkbox"/> Part-Time _____	If still disabled, give date you expect to return to work for this or any other employer. <input type="checkbox"/> Full-Time _____ <input type="checkbox"/> Part-Time _____	
Signature of Employee		Date

Attending Physician's Supplementary Statement

Name of Patient (Last, First, M.I.) - Please Print	Date of Birth
Nature of Sickness or Injury (Describe complications, if any)	
Nature of Treatment (Including surgery and medications prescribed) Provide prognosis and course of treatment specifically since last update.	
For Maternity Claims (Describe complications, if any)	
Date of Delivery _____	Type of Delivery <input type="checkbox"/> Normal <input type="checkbox"/> Cesarean
Give Dates of Treatment (Office)	Date of Next Appointment
(Hospital) From _____ To _____	Name and Address of Hospital
If patient has been referred to another physician, please provide name and address. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the patient competent to endorse checks and direct the use of the proceeds thereof? <input type="checkbox"/> Yes <input type="checkbox"/> No	
The patient should be able to work on:	or in about (Check one)
<input type="checkbox"/> Full-time Date _____	<input type="checkbox"/> 1 Month <input type="checkbox"/> 1-3 Months <input type="checkbox"/> 3-6 Months <input type="checkbox"/> Other _____
<input type="checkbox"/> Part-time Date _____	<input type="checkbox"/> 1 Month <input type="checkbox"/> 1-3 Months <input type="checkbox"/> 3-6 Months <input type="checkbox"/> Other _____
Have you discharged patient? (If "yes", give date) <input type="checkbox"/> Yes <input type="checkbox"/> No	Has disability terminated? (If "yes", give date) <input type="checkbox"/> Yes <input type="checkbox"/> No
Remarks	
Name of Attending Physician - Please Print	Tax Identification Number
Signature	Date Signed
Address (No. and Street, City, State, Zip Code)	Telephone Number

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.