

WEEKLY DISABILITY CLAIM FORM

Claim Administrator:

**Hewitt, Coleman & Associates
PO Box 6708
Greenville, South Carolina 29606**

Employer:

Plan Number:

EMPLOYEE'S STATEMENT

1. Name: _____ 2. SSN: _____

2. Date of Birth: _____ 4. Sex: _____ Male _____ Female

5. Address: _____

6. Reason for Disability (if accident, state when, where, and how it occurred) _____

TO PHYSICIAN, CLINIC OR HOSPITAL: I hereby authorize any physician or practitioner who has observed me for diagnosis or treatment, or for any disease or ailment; or any hospital or clinic where I have been a patient for such diagnosis, treatment, disease or ailment, to give full particulars thereof, including any prior medical history, to Hewitt, Coleman & Associates, the Plan's claim administrator. A photostat of this authorization shall be as valid as the original.

Employee Signature: _____ Date: _____

EMPLOYER'S STATEMENT

1. Employee's Name: _____ 2. Effective Date _____

3. First Day Not At Work _____ 4. Date Returned to Work _____

5. Is there a possibility of Workers' Compensation liability in this case? _____ Yes _____ No

6. Month in which last premium contribution was made: _____

7. Weekly Earnings _____ 8. Amount of Weekly Benefit _____

Employer: _____ Location: _____

Date: _____ Signed: _____

IMPORTANT: BOTH SIDES OF THIS FORM MUST BE COMPLETED

ATTENDING PHYSICIAN'S STATEMENT (Accident or Sickness)

Patient's Name: _____

Age: _____

1. Nature of sickness or injury (describe complications, if any)

Is condition due to pregnancy? No _____ Yes _____

2. On what date did symptoms first appear or accident happen?

3. On what date did patient first consult you for this condition?

4. Nature of surgical procedure, if any (describe fully)

5. Give dates of treatment:

6. Is patient still under care for this condition? Yes _____ No _____

If discharged, give date of discharge:

7. If patient is hospitalized, please show:

Date admitted: _____

Date discharged: _____

8. How long was or will patient be continuously or totally unable to work?

From: _____

Through: _____

9. Is condition due to injury or sickness arising out of patient's employment?

Yes _____ No _____

10. Has patient been released to return to work: _____ Yes Date to Return _____

_____ No Approx Date to Return _____

Signature of Attending Physician : _____ Date: _____

Print Attending Physician's Name: _____

Street Address: _____

City, State, Zip: _____

Phone#: _____

**FOR PROMPT CONSIDERATION IT IS IMPORTANT THAT ALL QUESTIONS ON THIS FORM
BE ANSWERED COMPLETELY**