P.O. Box 617
Concord, NH 03302-0617
800.527.5001
Fax: 603.415.3096

DISABILITY INCOME BENEFITS

Claim and Disability Status Form

INSTRUCTIONS:
1. Employee must complete, sign and date Employee Statement.
2. Employee must have their employer's Personnel Department Representative complete, sign and date Employer Statement.
3. Be sure to complete pages 1-4 of this form.

EMPLOYEE STATEMENT

1. Name of employee_______________________ Title _______________Date of birth ____/____/____
2. Sex _____Social Security # _______________ Department ______________Phone (____) ___________
3. Address of employee_______________________ City ______________State _______Zip ___________
4. When did the accident happen or illness begin? ____/____/____ 5. Is this condition related to employment? ❑ Yes ❑ No
6. Date last worked ____/____/____ 7. Date resumed work____/____/____ 8. If not back to work, when will you probably return?____/____/____
9. If injured, how and where did injury occur? ____

____

____

10. Are you or will you be receiving wage-replacement benefits from any other insurer? ❑ Yes ❑ No

If yes, name of insurer_______________________ Contact person and phone____________________

11. List all treating physicians:

Name_______________ Phone __________ Name _______________ Phone___________

Name_______________ Phone __________ Name _______________ Phone___________

12. Did you seek treatment at a hospital emergency room? If so, when and where? ______________________
13. Beneficiary Name ____

Address _______________________ City_______________State _______Zip ___________

Employee signature_______________________________________Date___________

EMPLOYER STATEMENT

1. Date hired____/____/____ 2. Date last worked____/____/____ 3. Date work resumed____/____/____
4. Hourly pay rate $ _______________ Effective date of pay rate____/____/____ 5. Class ___________________
6. Is this claim being filed for ❑ Accidental injury or ❑ Illness? 7. Is this condition work related? ❑ Yes ❑ No
8. Has the employee filed for Workers' Compensation benefits? ❑ Yes ❑ No
9. Regularly scheduled work week = __________ hours

Remarks ____

____

Employer ____

Contact Person ___________________________________ Phone (___) ___________________

Address _______________________ City_______________State ______ Zip ___________

Date______________ By ___________________________________ Title ___________________

Return signed original to: HEALTHTRUST. Employee and employer should retain a copy.

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DISABILITY INCOME BENEFITS

Agreement Concerning Benefits
Short-Term Disability Plan

INSTRUCTIONS: Employee must complete, sign and date this agreement as the claimant and have it witnessed and signed.

Claimant: ______________________ **Employer:** ______________________

Address: ______________________ **Date of Disability:** ______________________

In consideration of the **[advance]** payment of weekly income benefits made to me by my employer under my employer's Short-Term Disability Plan (the "Plan"), administered by HealthTrust, I represent, acknowledge and agree that:

1. I have not received and am not currently receiving any other benefits or payments for loss of income due to my disability from Workers' Compensation, automobile insurance, individual disability or other insurance, any state or federal disability income or unemployment benefit law or similar law, or any other type or source of wage replacement;

2. My benefits under the Plan will be reduced by any such benefits or payments for loss of income for which I may be eligible while disabled, and that I will not be eligible for any benefits under the Plan for any period that I am eligible to receive benefits from Workers' Compensation;

3. If I receive any such benefits or payments during my disability, regardless of the source or amount, I will immediately notify my employer and HealthTrust of such benefits or payments and will pay back all amounts paid to me by the Plan which exceed the amount actually due to me under the terms of the Plan;

4. To the extent benefits are paid to me pursuant to the terms of the Plan, my employer and HealthTrust will be subrogated and succeed to any recovery or right of recovery I might have against (i) any third party who is responsible for causing my disability, or (ii) any workers' compensation carrier, other insurer or other provider of income replacement benefits which are paid or payable to me due to my period of disability; and

5. I have an obligation to inform my employer and HealthTrust of any such income replacement benefits or payments that may be available and to provide such information and assistance, and execute such documents, as HealthTrust may require to assist in the recovery of such benefits or payments.

I understand that my employer and HealthTrust, in reliance on the above statements and promises, will agree to advance benefit payments to me from the Plan.

____
Witness

____
Address

____
Date

____
Claimant

____
Address

____
Date

Return signed original to: HEALTHTRUST. Employee and employer should retain a copy.

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DISABILITY INCOME BENEFITS

Patient's Authorization to Release Information

INSTRUCTIONS: 1. Employee must complete, sign and date this release. 2. Employee must provide a copy to physician.

I authorize my medical care provider(s) to disclose to HealthTrust, any information relating to my current medical condition necessary to process my claim for disability income benefits under my employer's Short-Term Disability Plan.

With respect to my authorization to release my medical information, I understand and acknowledge that:

> I can revoke this authorization at any time by giving my written revocation to my physician or other medical care provider.
>
> My healthcare treatment by my physician or other medical care provider will not be affected if I refuse to sign this form.
>
> I am authorizing disclosure of information protected under federal privacy law and that the information, once disclosed, could be subject to re-disclosure by the recipient and no longer be protected by federal privacy law.
>
> If I do not revoke it, this authorization will expire 18 months from the date that I sign it.
>
> I am entitled to receive a signed copy of this authorization and a copy will serve as an original.

I acknowledge that this authorization is subject to the terms set forth above, all of which I have read and understand.

Name of Patient ____

Address ____

City ______________________________ **State** _______ **Zip** ________________

Date of Birth ____/____/____ **Social Security Number**______________________________

Patient's Signature ______________________________ **Date** ________________

Return signed original to: HEALTHTRUST. Employee and Physician or other Medical Care Provider(s) should retain a copy.

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DISABILITY INCOME BENEFITS

Physician's Statement

INSTRUCTIONS: Physician must complete, sign and date this form.

Patient Name: ______________________________ Date of Birth: ______________

1. Is this condition work related? ❑ Yes ❑ No

2. Diagnosis and Diagnosis Code ______________________________

   ____

   ____

   ____

3. (a) Date of first treatment ____/____/____ (b) Date of most recent treatment ____/____/____ (c) Date of delivery ____/____/____

4. The patient has been totally and continually disabled (unable to work) from ____/____/____ through ____/____/____

5. Assessment:

   (a) Describe the patient's current physical and mental limitations and work activity restrictions: ______________________________

   ____

   ____

   ____

   (b) How long will the described limitations impair the patient? ______________________________

   (c) Describe current treatment: ______________________________

   ____

   (d) Will the patient require surgery? ______________________________ If so, date of surgery ____/____/____

6. Prognosis:

   (a) When do you expect a fundamental or marked change in the patient's condition? ______________________________

   (b) When do you anticipate the patient can return to work? ______________________________

   (c) Date of next follow-up visit ____/____/____

Physician's name (*please print*) ______________________________ M.D. Date ______________

Physician's signature ______________________________ Phone ______________

Address ______________________________

City ______________________________ State ______________ Zip ______________

Return signed original to: HEALTHTRUST. Employee, Employer and Physician or other Medical Care Provider(s) should retain a copy.