

Disability Claim Statement

Non-Occupational Sickness or Accident

NATIONAL EMPLOYEES
HEALTH PLAN

Employee Statement

Employee Name: _____ Participant ID: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Date of Birth: _____ Phone Number: _____
Occupation: _____ Local Union No.: _____

Claim Information

	Month	Day	Year	Time a.m./p.m.
Date of first symptoms:	_____	_____	_____	_____
Date of first treatment	_____	_____	_____	_____
Date of injury	_____	_____	_____	_____
How did the accident happen?	_____			
Where did the accident occur?	_____			
Was disability caused by employment?			Yes _____	No _____
If yes, has a claim been filed or will a claim be filed under Workmen's Compensation?			Yes _____	No _____

To Whom it May Concern

I hereby authorize any hospital, physician, employee, insurance company, or any other organization to release to National Employees Health Plan or its authorized representative, any and all information you may have with respect to any sickness or injury, including past and present medical history, diagnoses, consultations, prescriptions, examinations, treatment, operative procedures, X-rays and pathological findings. I agree that a photostatic copy of this authorization shall be considered as effective and valid as the original.

Employee Signature

Date

Employer Statement

Company Name: _____ Phone Number: _____
Address: _____
Occupation of Employee: _____ Has employee returned to work? Yes _____ No _____
Date employee last worked: Month: _____ Day _____ Year _____ Time _____ a.m./p.m.
Date employee returned to work: Month: _____ Day _____ Year _____ Time _____ a.m./p.m.
Regularly employed and actively working when disabled? Yes _____ No _____
Was disability caused by employment? Yes _____ No _____
If yes, has a claim been filed or will a claim be filed under worker's compensation: Yes _____ No _____

Printed Employer Name Representative

Employer Signature Representative

Official Title

Date

Please forward completed form to:

National Employees Health Plan • P.O. Box 37502 • Oak Park, MI 48237-0502
In Michigan call 1-586-693-4400 • Outside of Michigan call 1-800-447-1032 • Fax 586-693-4820

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Attending Physician's Statement

Patient Name: _____ Date of Birth: _____

1. Diagnosis and concurrent conditions (if diagnosis code other than "ICDA" used, give name): _____

2. Is condition due to injury or sickness:

A) Arising out of patient's employment? Yes _____ No _____

B) Arising out of an accident? Yes _____ No _____

C) Arising out of a pregnancy? Yes _____ No _____

If yes to pregnancy, expected date of delivery: _____

3. Report of Services (If previous form submitted to this carrier, you need only show dates since last report)

Date of Service	Place of Service	Description of Surgical or Medical Services Rendered
_____	_____	_____
_____	_____	_____
_____	_____	_____

* Place of Service Codes:

(O) Doctor's Office / (IH) Inpatient Hospital / (NH) Nursing Home / (H) Patient's Home / (OH) Outpatient Hospital / (OL) Other Locations

4. Date symptoms first appeared or accident occurred (mm/dd/yy): _____

5. Date patient first consulted you for this condition (mm/dd/yy): _____

6. Has patient ever had same or similar condition: Yes ___ No ___

If yes, please identify: _____

7. Is patient still under your care for this condition: Yes ___ No ___

8. Dates patient was continuously totally disabled (unable to work): From: _____ To: _____

9. Dates patient was partially disabled: From: _____ To: _____

10. If still disabled, date patient should be able to return to work (mm/dd/yy): _____

11. If partially disabled, list restrictions: _____

Physician Signature

Date

Physician Printed Name / Type of Degree

Tax ID or Social Security Number

Street Address

Telephone Number

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