FLEXIBLE BENEFIT PLANS
PO BOX 385
TAYLORSVILLE NC 28681
828-632-4970

NOTIFICATION OF CLAIM

Claim Form for Disability Income Benefits

Print Form

EMPLOYEE'S STATEMENT: **To Be Completed By The Employee**

Name of Employee	□ Married □ Single	□ Widowed □ Divorced	Date of Birth	□ Male □ Female
Street Address (No. & Street, City, State, Zip)				Phone Number
On what date were you first unable to work because of your disability? (Mo. Day Yr.)				
For what injury or sickness are you being treated?		Date you returned to work (Mo. Day Yr.)		If not yet working when do you expect to? (Mo. Day Yr.)

CLAIM IS DUE TO: (Complete One of These Sections)	Section 1 AN INJURY	A. DATE OF ACCIDENT? B. WHERE DID IT OCCUR? C. HOW DID IT HAPPEN? D. WAS THE ACCIDENT CONNECTED WITH YOUR EMPLOYMENT?
	Section 2 A SICKNESS	A. WHEN DID SYMPTOMS BEGIN? B. WHEN DID YOU FIRST SEE A DOCTOR FOR IT? C. NAME OF DOCTOR? D. DID YOU HAVE SURGERY? E. ON WHAT DAY WAS THE SURGERY?

ARE YOU COVERED BY ANY OTHER DISABILITY PLAN? □ YES □ NO

IF YES, NAME & ADDRESS OF OTHER COMPANY: _____

POLICY NUMBER OF OTHER PLAN: NAME OF INSURED PERSON:

EMPLOYEE'S SIGNATURE DATE

EMPLOYER'S STATEMENT: **To Be Completed By the Employer**

1. Is This Claim Covered By Worker's Compensation?	□ YES	□ NO				
2. Is Disability Due In Any Way to the Employee's Occupation?	□ YES	□ NO				
3. Date Employee Was Last Actively At Work?						
4. Date Employee Resumed Work?						
5. Has Employment Terminated?	□ YES	□ NO Date? _____				
6. Why Did Employee Cease Work?	☐	Illness	☐	Injury	☐	Vacation
	☐	Quit	☐	Dismissed	☐	Lay Off
	☐	Leave of Absence				
7. What was the Last Date Employee was Paid for (after exhaustion of all sick leave and vacation time)?						

EMPLOYER'S SIGNATURE DATE

TITLE

COMPANY NAME DEPARTMENT

REV: 092707FBP

DISABILITY CLAIM FORM

FLEXIBLE BENEFIT PLANS
PO BOX 385
TAYLORSVILLE NC 28681

TO BE COMPLETED BY THE PATIENT

Patient's Name and Address	
Date of Birth	Social Security No.

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.

Patient's Signature _____ Date _____

ATTENDING PHYSICIAN'S STATEMENT

Diagnosis and Concurrent Conditions: *(If Diagnosis Code Other Than ICD Used, Give Name):*			
Is Condition Due to Injury/Sickness Arising Out of Patient's Employment?		Yes No	
Condition Due to Pregnancy?	Yes No	If Yes, Approximate Date Pregnancy Commenced: Date of Delivery:	
Date Symptoms First Appeared or Accident Happened:			
Date Patient First Consulted You For This Condition:			
Has Patient Ever Had Same or Similar Condition?		Yes, When and Describe: No	
Is Patient Still Under Your Care For This Condition?		Yes No	
Patient Was Continuously Disabled (Unable to Work) **From:** **Thru:**			
If Still Disabled, Date Patient Should Be Able To Return to Work (or approximate date):			

Physicians Name (Print) Degree Date

Physician's Complete Address

Physician's Telephone SS# Or ID#

PHYSICIAN'S SIGNATURE