

GEMGroup

BRANDYWINE CORPORATE CENTER
SUITE 303 • 650 NAAMANS RD.
CLAYMONT, DE 19703

DISABILITY STATEMENT OF CLAIM

MEMBER'S STATEMENT:

LOCAL UNION NO. _____

Insured's Name _____

Social Security # _____

Claim is for: Self Wife Unmarried Child

Name of Patient: _____ Date of Birth: _____ Sex: _____

Claim is due to: Sickness which commenced on _____

Accident which occurred on _____ at _____

Describe: _____

If claim is for you, how long were or will you be physically unable to work?

From _____ through _____

Did this accident or sickness result from any employment? Yes No

Craft: _____

Last Employer preceding date of claim: _____

Last day worked: _____

Have you applied for and/or received Unemployment Compensation Benefits at any time after you became disabled? Yes No

If you received such benefits, state the weeks for which you were eligible, the amount of your weekly benefits, identify the Unemployment Compensation Office where you made application for benefits and the claim number assigned to your Unemployment Compensation Benefits:

Are you, your spouse, or your dependent children entitled to benefits from any other kind of group health insurance or plan including Blue Cross? Yes No

Name and address of other insurance company and/or organization: _____

I.D./Certificate No. _____ Group Policy/Contract No. _____

Date: _____ Signature of Insured: _____ Age: _____

Mailing Address: _____
Street City State Zip

Telephone Number: () _____

(Over)

DISABILITY STATEMENT OF CLAIM (Cont.)

DOCTOR'S STATEMENT:

Patient's Name: _____

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

Did this sickness or injury arise out of the patient's employment? Yes No

If yes, explain _____

Is disability due to pregnancy? Yes No

If yes, what was the approximate date of commencement of pregnancy? _____

Nature of surgical or obstetrical procedure, if any (describe fully) _____

Identify procedure code / /

Date performed _____ Where performed (if in hospital) _____

Inpatient Outpatient Charge for this procedure \$ _____

On what date did you first treat patient? _____

Frequency of treatments _____

In hospital medical visits: From _____, 20____ through _____, 20____

Office visits (dates) _____

The patient has been continuously disabled (unable to work) from (dates) _____, 20____

through _____, 20____

If still disabled, when should patient be able to return to work? _____, 20____

Date: _____ Signed: _____ Degree: _____

(Attending Physician)

Doctor's Name (please print) _____

Physician's Social Security No. _____

Address _____

Street

City

State

Zip

Telephone () _____