

Group Disability Claim Form

Employer Section

Employer Name	Plan Number	
Employee Name	Soc Sec #	Date of Birth
Address		
Present Weekly Wage \$	Amount of Federal Income Tax to be withheld \$	

Date the Employee became totally disabled: ____/____/____

Date the Employee may return to Regular duties: ____/____/____

Is this disability due in any way to the employee's occupation? Yes No

Is this disability covered by Workman's Compensation? Yes No

Signature of Employer Representative

Date

Name of Employer Representative

Physician Section

Disability is a result of:

- Illness
- Injury
- Pregnancy

Date of first symptom: ____/____/____

Date of accident: ____/____/____

Expected delivery date: ____/____/____

First consulted for this condition ____/____/____

Employee return to work date ____/____/____

Total Disability from ____/____/____

to ____/____/____

Partial Disability from ____/____/____

to ____/____/____

Has the employee ever had same or similar symptoms? Yes No

Reason for Disability/Condition Diagnosed: _____

Restrictions: _____

Name & Degree of Attending Physician

Tax Identification Number

Street Address

Telephone Number

City, State, Zip Code

Physician Signature

Date

SUBMIT COMPLETED FORM TO:

CORE *Benefits, Inc.*

P.O. Box 80465

Fort Wayne, IN 46898-0465

Phone: 260.492.7451 866.744.8482 Fax: 260.492.7292