



Activa Benefit Services, Inc.  
 P.O. Box 37  
 Farmington, MI 48332-0037  
 Phone (877) 827-1414 or (616) 588-5340  
 Fax (616) 588-7915

## SHORT TERM DISABILITY BENEFITS

### INSTRUCTIONS FOR FILING A DISABILITY CLAIM

**THIS FORM IS FOR SHORT-TERM DISABILITY BENEFITS ONLY.  
 TO AVOID DELAY OR RETURN, PLEASE FOLLOW THESE INSTRUCTIONS.**

- To the Claimant:
- A. Complete and sign the Claimant section.
  - B. Have the Attending Physician complete and sign the Attending Physician section.
  - C. Return the fully completed form to your Employer/Administrator who will submit the form to the claim office.

### TO BE COMPLETED BY THE CLAIMANT

Name of Employee (Last Name)	(First name)	(M.I.)	Date of Birth	Social Security No.	Gender <input type="checkbox"/> M <input type="checkbox"/> F
------------------------------	--------------	--------	---------------	---------------------	-----------------------------------------------------------------

Address (Street)	(City)	(State)	(Zip Code)	Telephone No. (     ) -
------------------	--------	---------	------------	----------------------------

Date of accident or beginning of sickness	First date you were unable to work	Date you plan to return to work
-------------------------------------------	------------------------------------	---------------------------------

Was your Disability caused by any of the following:      Accident  **Yes**  **No**      Auto accident  **Yes**  **No**

Work related injury  **Yes**  **No**      If work related has a Workers Compensation claim been filed  **Yes**  **No**

Describe, in your own words, the condition(s) affecting you (if accident, describe circumstances and location of accident).

Please list any hospitals, clinics or physicians that treated you for your illness or injury	Name	Complete Address	Treatment Period
----------------------------------------------------------------------------------------------	------	------------------	------------------

Please give your occupation and describe your job duties in detail. What percentage of your job requires physical labor?

Please list all benefits you are receiving or eligible to receive under any other Group Insurance, Government Plan or Automobile Mandatory No-Fault coverage. Include name, address and telephone number of other Carrier.

Benefit	Address	Gross Weekly Amount	Date began	Paid thru date

THIS IS TO CERTIFY THAT THE FACTS AS INDICATED ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature of Employee: \_\_\_\_\_ Date Signed: \_\_\_\_\_

#### Authorization to Release Information

To all physicians and other health care professionals, and all hospitals and other health care institutions: You are authorized to provide Activa Benefits information concerning health care advice, treatment or supplies provided to the Patient (including those relating to mental illness or substance abuse, HIV infection, AIDS, or AIDS related complex). This information will be used for the purpose of evaluating and administering claims for benefits. This authorization is valid for the term of coverage for the policy or contract under which a claim has been submitted. I know that I have the right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Signature of Employee: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**TO BE COMPLETED BY THE ATTENDING PHYSICIAN**

Diagnosis and concurrent conditions, including ICD-9 or DSM-V code.

Is this condition due to pregnancy?  **Yes**  **No** If "yes" please provide the information below, if applicable.

Approximate date pregnancy commenced

Estimated date of confinement

Date of delivery

Complications, if any

Is the condition due to injury or illness caused by the patient's employment?  **Yes**  **No**

Date symptoms first appeared or accident happened.

Date patient first consulted you for this condition.

Dates of services – include date of next appointment (if previous form submitted to this payer, you need show only dates since last report)

Has the patient ever had same or similar condition?  **Yes**  **No** If "yes" when and describe.Patient still under your care for this condition?  
 **Yes**  **No**Has the patient been hospital confined?  **Yes**  **No** If "yes" confined from: \_\_\_\_\_ thru: \_\_\_\_\_

Name and Address of hospital: \_\_\_\_\_

Nature of surgical procedure, if any: \_\_\_\_\_

 Inpatient  Outpatient Date performed: \_\_\_\_\_

Patient was continuously totally disabled – (unable to work).

If still disabled, date patient should be able to return to work.

From: \_\_\_\_\_ Thru: \_\_\_\_\_

Reason why this condition prevents patient's return to full-time employment.

Date

Physician's Name (please print)

Signature

Degree

Tax Identification Number

Telephone Number

Street Address

City or Town

State or Province

Zip/Postal Code

**TO BE COMPLETED BY THE EMPLOYER**

PLEASE CHECK THE APPROPRIATE BOXES REGARDING THE INSURED'S EMPLOYMENT STATUS.

 Exempt  Non-Exempt  Salaried  Hourly  Full-time  Part-time

Basic earnings per week

Date of last change in Earnings

Date Hired

Effective date of Insurance

Last date worked

Number of hours

Date returned to work

Salary continuance paid thru date

Name of Employer

Division

Address (street)

(City)

(State)

(Zip Code)

Telephone Number

( ) -

THIS IS TO CERTIFY THAT THE FACTS AS INDICATED ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature of Authorized Representative: \_\_\_\_\_ Date Signed: \_\_\_\_\_