

**CLAIM FORM  
GROUP DISABILITY BENEFITS**

NOTE: PATIENT IS RESPONSIBLE FOR COMPLETION OF FORM BY PHYSICIAN WITHOUT EXPENSE TO EMPLOYER/ADMINISTRATOR.

ADMINISTERED BY

**PROFESSIONAL BENEFITS SERVICES  
2959 LUCERNE SE, SUITE 205  
GRAND RAPIDS, MI 49546**

**SECTION I TO BE COMPLETED BY EMPLOYEE OR MEMBER**

NAME, IN FULL, OF EMPLOYEE OR MEMBER PATIENT COVERED		SEX M <input type="checkbox"/> F <input type="checkbox"/>	DATE OF BIRTH	SOCIAL SECURITY NO.
DATE ACCIDENT HAPPENED OR SICKNESS BEGAN	HOUR <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	DESCRIBE INJURIES OR NATURE OF SICKNESS		
IF AN ACCIDENT, WHERE AND HOW DID IT HAPPEN?		WAS YOUR INJURY OR SICKNESS CAUSED BY WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME OF ATTENDING PHYSICIAN	
<b>REIMBURSEMENT</b> →	I agree to reimburse the PLAN for any overpayments which are in excess of what the PLAN allows. I further agree to reimburse the PLAN, all benefits paid to me or on my behalf, should I recover any money for the same accident or illness for which benefits were paid. This agreement applies to all recoveries, including benefits paid or recovered under any State, or Federal Workers Compensation Statute, whether by redemption, voluntary payment, compromise, settlement, court order or any other form.			
<b>INFORMATION AUTHORIZATION</b> →	I hereby authorize my employer or Professional Benefits Services to release or obtain any information necessary to determine benefits under this Plan. A photocopy of this release will carry the same authority as the original.			
DATE	SIGNATURE OF EMPLOYEE OR MEMBER PATIENT COVERED			
MAILING ADDRESS	STREET	CITY	STATE	ZIP CODE

**SECTION II TO BE COMPLETED BY ATTENDING PHYSICIAN OR DOCTOR**

<b>Complete for Disability</b>	Diagnosis and concurrent conditions of Above Patient (If diagnosis code other than ICDA used, give name)	
	Date Most Recently Confined As In-Patient to Hospital? (If applicable)	Was the Patient Treated at an Emergency Facility Prior to Your Care? Yes <input type="checkbox"/> No <input type="checkbox"/> If So, Give Date and Name of Facility:
	Is condition Due to Injury or Sickness Arising Out of Patient's Employment? Yes <input type="checkbox"/> No <input type="checkbox"/>	Other Recent Dates of Service (Direct Care or Treatment)?
	Is Condition Due to Pregnancy? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Approximate Date Pregnancy Commenced?	Date You First Rendered Surgical or Medical Services for This Patient's Condition?
	Did Patient Ever Have Same or Similar Condition? Yes <input type="checkbox"/> No <input type="checkbox"/> If "YES" When and Describe:	Is Patient Still Under Your Care for This Condition? Yes <input type="checkbox"/> No <input type="checkbox"/> If "NO", DATE SERVICES TERMINATED:
<b>***** TO THE DOCTOR → (PLEASE REVIEW CAREFULLY BEFORE AUTHORIZING) ← *****</b>		
<b>"TOTAL DISABILITY" as defined by the group health plan covering this patient means this employee has incurred "A BODILY INJURY OR ILLNESS WHICH WHOLLY PREVENTS HIM/HER FROM ENGAGING IN OR PERFORMING ANY AND/OR ALL WORK FOR COMPENSATION OR PROFIT." This patient is not or has not been actively at work.</b>		
I, HEREBY, CERTIFY THIS PATIENT WAS CONTINUOUSLY AND TOTALLY DISABLED USING THE ABOVE PLAN DEFINITION	IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK? (STATE OR ESTIMATE)	
FROM (Mo.) (Day) (Year) THROUGH (Mo.) (Day) (Year)	(Mo.) (Day) (Year)	
Date Physician's Name (Print) Degree	Physician's Signature (NO FACSIMILE STAMPS, PLEASE!) Telephone	
Street Address	City or Town State or Province Zip Code	

**SECTION III TO BE COMPLETED BY EMPLOYER OR PLAN ADMINISTRATOR**

Group Plan No.	Name of Company or Plan	Classification
Effective date - EMPLOYEE'S coverage in force? <input type="checkbox"/> Yes <input type="checkbox"/> No - Show termination date	(Mo.) (Day) (Year) (Mo.) (Day) (Year)	<b>COMPLETE FOR DISABILITY:</b> Employee's Duties - Occupation/Job Description
Is coverage reinstated, show date reinstated	(Mo.) (Day) (Year)	Date Employed
Has Employee made claim for Workmen's Compensation? Yes <input type="checkbox"/> No <input type="checkbox"/>	Is He/She entitled to such benefits? Yes <input type="checkbox"/> No <input type="checkbox"/>	Basic Wage Or Salary \$ Month Week
Do you recommend payment of this claim? Yes <input type="checkbox"/> No <input type="checkbox"/>	Remarks:	Employee's last date worked _____ Hour _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M. Has He/She returned to work? Yes <input type="checkbox"/> - When? _____ No <input type="checkbox"/> - When expected? _____
Date	Employer or Plan Administrator	Signature Title