Disability Claim Statement

Non-Occupational Sickness or Accident

NATIONAL EMPLOYEES HEALTH PLAN

Employee Statement

Employee Name: ______________________ Participant ID: ______________________

Address: ____

City: ______________________ State: __________ Zip Code: __________

Date of Birth: ______________________ Phone Number: ______________________

Occupation: ______________________ Local Union No.: ______________________

Claim Information

	Month	Day	Year	Time a.m./p.m.
Date of first symptoms:	____	____	____	____
Date of first treatment	____	____	____	____
Date of injury	____	____	____	____

How did the accident happen? ____

Where did the accident occur? ____

Was disability caused by employment? Yes ______ No ______

If yes, has a claim been filed or will a claim be filed under Workmen's Compensation? Yes ______ No ______

To Whom it May Concern

I hereby authorize any hospital, physician, employee, insurance company, or any other organization to release to National Employees Health Plan or its authorized representative, any and all information you may have with respect to any sickness or injury, including past and present medical history, diagnoses, consultations, prescriptions, examinations, treatment, operative procedures, X-rays and pathological findings. I agree that a photostatic copy of this authorization shall be considered as effective and valid as the original.

______________________ ______________________

Employee Signature Date

Employer Statement

Company Name: ______________________ Phone Number: ______________________

Address: ____

Occupation of Employee: ______________________ Has employee returned to work? Yes ______ No ______

Date employee last worked: Month: ______ Day ______ Year ______ Time ______ a.m./p.m.

Date employee returned to work: Month: ______ Day ______ Year ______ Time ______ a.m./p.m.

Regularly employed and actively working when disabled? Yes ______ No ______

Was disability caused by employment? Yes ______ No ______

If yes, has a claim been filed or will a claim be filed under worker's compensation: Yes ______ No ______

______________________ ______________________

Printed Employer Name Representative Employer Signature Representative

______________________ ______________________

Official Title Date

Please forward completed form to:

National Employees Health Plan • P.O. Box 430 • Sterling Heights, MI 48311

Phone 800-648-8200 • Fax 586-693-4760

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NATIONAL EMPLOYEES HEALTH PLAN

Attending Physician's Statement

Patient Name: ____________________ Date of Birth: ____________________

1. Diagnosis and concurrent conditions (if diagnosis code other than "ICDA" used, give name): ____________________

2. Is condition due to injury or sickness:
   - A) Arising out of patient's employment? Yes ____ No ____
   - B) Arising out of an accident? Yes ____ No ____
   - C) Arising out of a pregnancy? Yes ____ No ____
     If yes to pregnancy, expected date of delivery: ____________

3. Report of Services (If previous form submitted to this carrier, you need only show dates since last report)

Date of Service	Place of Service	Description of Surgical or Medical Services Rendered

* Place of Service Codes:
(O) Doctor's Office / (IH) Inpatient Hospital / (NH) Nursing Home / (H) Patient's Home / (OH) Outpatient Hospital / (OL) Other Locations

4. Date symptoms first appeared or accident occurred (mm/dd/yy): ____________
5. Date patient first consulted you for this condition (mm/dd/yy): ____________
6. Has patient ever had same or similar condition: Yes ___ No ___
   If yes, please identify: ____________
7. Is patient still under your care for this condition: Yes ___ No ___
8. Dates patient was continuously totally disabled (unable to work): From: ________ To: ________
9. Dates patient was partially disabled: From: ________ To: ________
10. If still disabled, date patient should be able to return to work (mm/dd/yy): ________
11. If partially disabled, list restrictions: ____________

Physician Signature ____________ Date ____________

Physician Printed Name / Type of Degree ____________ Tax ID or Social Security Number ____________

Street Address ____________ Telephone Number ____________

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