Group Disability Claim Form

Employer Section

Employer Name	Plan Number	
Employee Name	Social Security #	Date of Birth
Address (Street Name, City, State & Zip)		
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 Date of first symptom: ______/______/______
Injury Date of accident: ____/______/______
Pregnancy 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 Fax: 260.492.7292