



### **Claim Form for Disability Benefits**

- Section 1**      Attending Physician's Statement – to be completed by the physician who is treating the employee.
- Section 2**      Employer's Statement – to be completed by the employer's authorized representative.
- Section 3**      Employee's Statement – to be completed by the employee who is applying for Short Term Disability benefits.

**All three sections must be fully completed, dated and signed. Send the completed claim form to :**

**American Community Mutual Insurance Company  
39201 Seven Mile Road  
Livonia, MI 48152-1094**

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American Community Mutual Insurance Company**

39201 Seven Mile Rd.  
Livonia, MI 48152-1094  
(734) 591-9000 (734) 591-8056 Fax

**Section 1  
Attending  
Physician's  
Statement**

**TO BE COMPLETED BY PHYSICIAN**

1. Patient's full name \_\_\_\_\_ Date of Birth \_\_\_\_\_ S.S. # \_\_\_\_\_
2. Patient's Condition is the result of  Illness  Injury  Pregnancy  Mental/Nervous Condition  
If pregnancy, expected date of delivery: \_\_\_\_\_.
3. Diagnosis (including complications) \_\_\_\_\_  
ICD9 Codes: \_\_\_\_\_ Subjective Symptoms: \_\_\_\_\_  
Physical Findings:  
Test \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_  
Test \_\_\_\_\_ Date: \_\_\_\_\_ Results: \_\_\_\_\_  
Blood Pressure \_\_\_\_\_ Date \_\_\_\_\_
4. Date of onset of this condition: \_\_\_\_\_ List all dates of treatment for this condition since the patient ceased work \_\_\_\_\_ Date of next visit: \_\_\_\_\_
5. Has the patient been referred to any other physician?  Yes  No If yes, name and address: \_\_\_\_\_  
\_\_\_\_\_
6. Was patient hospitalized for this condition?  Yes  No If yes, date admitted \_\_\_\_\_ date discharged \_\_\_\_\_  
Name and address of hospital: \_\_\_\_\_
7. Was surgery performed?  Yes  No If yes, date \_\_\_\_\_ procedure \_\_\_\_\_
8. **Impairment**  
**What are the patient's current physical limitations and restrictions?**  
 No limitation of functional capacity; capable of heavy work, no restrictions. (Lifting 100 lbs. maximum with frequent lifting and/or carrying objects weighing up to 50 lbs)  
 Medium manual activity. (Lifting 50 lbs maximum with frequent lifting and/or carrying of objects weighing up to 25 lbs)  
 Slight limitation of functional capacity; capable of light work. (Lifting 20 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 10 lbs, unable to walk or stand for significant periods of time)  
 Moderate limitation of functional capacity. (capable of clerical or sedentary activity)  
 Severe limitation of functional capacity. (incapable of even minimal activity)  
**Psychiatric Impairment, if applicable**  
 Essentially good functioning in all areas. Occupationally and socially effective.  
 Slight difficulty in occupational functioning, but generally functioning well.  
 Moderate impairment in occupational functioning. Limited in performing some occupational duties.  
 Major impairment in several areas—work, family relations. Avoidant behavior, neglects family, is unable to work.  
 Inability to function in most areas.
9. Date patient ceased work due to this impairment: \_\_\_\_\_ Date patient able to return to work: \_\_\_\_\_

Attending physician's name: \_\_\_\_\_ Phone # \_\_\_\_\_  
Address: \_\_\_\_\_ Tax ID No: \_\_\_\_\_  
Signature \_\_\_\_\_ Date signed \_\_\_\_\_

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**Section 2**  
**Employer's**  
**Statement**

**To Be Completed by the Employer**

Employee's Name	Social Security Number	Date of Birth
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Company's Name	Group Policy Number
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Date employee was hired	What was the employee's regularly scheduled work week? Hours per week _____ Scheduled workdays M-F _____ Other _____ Hourly/Weekly rate of pay _____
Date employee became insured under this plan.	

Was the employee on Qualified Family Leave when disability began?  Yes  No  
 Date Leave of Absence started under Family Leave Act \_\_\_\_\_

Based on the employer/employee premium contributions made over the last 3 years, what percentage of the short-term disability benefit is considered taxable? \_\_\_\_\_% (See Section 7 of IRS Publication 15-A for information on determining the taxable percentage.)

What was the employee's permanent job on his or her last day of work?

When was the employee's last day worked?  (month) (day) (year)	When did employee return to work?  (month) (day) (year)
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If not back to work, when do you expect the employee to return to work?

Is the employee entitled to Worker's Compensation benefits for this disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, has a claim for Worker's Compensation been filed? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Check the items below that relate to the employee's job.

Activity	N/A	Occasionally (33 % of time on job)	Frequently (34-65 % of time on job)	Continuously (67-100% of time on job)
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Reaching/Working Overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Keyboard Use/Repetitive Hand Motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Activity	Frequency	Weight
<input type="checkbox"/> Pushing/Pulling	_____	_____ lbs
<input type="checkbox"/> Lifting	_____	_____ lbs
<input type="checkbox"/> Carrying	_____	_____ lbs

Can the job be modified to accommodate the disability either temporarily or permanently?  Yes  No If yes, please explain:

Name (please print)	Title	Phone Number
Signature	Date	

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**Section 3  
Employee's Statement**

**To Be Completed by the Employee**

1. Last Name _____	First Name _____	Middle Initial _____	Social Security Number (Please copy from your card) _____
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2. Address (Street) _____	City _____	State _____	Zip _____
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3. Telephone Numbers Home: (____) _____ Work: (____) _____	Date of birth (MM/DD/YY) _____	<input type="checkbox"/> Male <input type="checkbox"/> Single <input type="checkbox"/> Female <input type="checkbox"/> Married	Employer Name _____
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4. If Injury:  
Date of Injury \_\_\_\_\_ Place of Injury \_\_\_\_\_ How did injury occur? \_\_\_\_\_  
\_\_\_\_\_

5. If Sickness:  
Date you were first treated by a physician \_\_\_\_\_ Nature of illness \_\_\_\_\_  
Name of Physician \_\_\_\_\_  
Address of Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

6. Is your condition related to your occupation?  Yes     No    If yes, please explain \_\_\_\_\_

7. Is the claim due to an auto accident?  
 Yes    If yes, Insurance Company Name \_\_\_\_\_ Policy # \_\_\_\_\_  
 No    Address: \_\_\_\_\_  
\_\_\_\_\_

8. Give all dates of attendance by physician. \_\_\_\_\_

9. If surgery was performed, describe operation and give date. \_\_\_\_\_

10. When were you first totally disabled by this condition so that you were unable to work?  
\_\_\_\_\_ at \_\_\_\_\_ o'clock \_\_\_\_\_ a.m.  
Month    Day    Year    p.m.

11. What aspect of your condition made you unable to work? \_\_\_\_\_

12. Have you returned to work?  No     Yes  
If yes, when did you return to work? \_\_\_\_\_ at \_\_\_\_\_ o'clock \_\_\_\_\_ a.m.  
Month    Day    Year    p.m.

13. If you have not returned to work, when do you expect to return?  
\_\_\_\_\_ at \_\_\_\_\_ o'clock \_\_\_\_\_ a.m.  
Month    Day    Year    p.m.

**Authorization to Hospital, Doctor or Other Insurance Company**

I hereby request and authorize any hospital, physician, or other person who has attended or examined me to furnish to AMERICAN COMMUNITY MUTUAL INSURANCE COMPANY of LIVONIA, MICHIGAN or its representative any and all information concerning any illness or injury I may have suffered, medical history, consultations, prescriptions, or treatments including x-rays and copies of all hospital or medical records, that same may be included as part of the proofs of loss submitted by me to the Company. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I am entitled to receive a copy of this authorization.

Date \_\_\_\_\_

Witness \_\_\_\_\_

Signature of Employee \_\_\_\_\_

**NOTICE: For your protection, Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.**