Supplemental Form for Short Term Disability Benefits

AMERICAN COMMUNITY
MUTUAL INSURANCE COMPANY

39201 Seven Mile Road
Livonia, MI 48152-1094
800-991-2642 734-591-9000

To Be Completed by the Employee

Last Name	First Name	Middle Initial	Social Security Number:

Address (Street)	City	State	Zip	Telephone Number:

Date illness began or accident occurred:	Last date of work:	Date returned to work:

If not returned to work, what prevents you from returning to work?

What are your present activities?

What important duties of your occupation are you unable to perform?

On what date will you be able to return to work?

_____ _____
Signature of employee date signed (MM/DD/YY)

To Be Completed by the Physician

Nature of sickness or inury (include description of complications, if any)

Plan of treatment:

Give dates of treaments since last report:

Is patient still under your care for this condition? ☐ Yes ☐ No	If no longer under your care, date discharged from care:
How long was or will the patient be continuously totally disabled (unable to work)? From _____ (mm/dd/yy) to _____ (mm/dd/yy)	If accident, how long will the patient be partially disabled? From _____ (mm/dd/yy) to _____ (mm/dd/yy)
Telephone Number of Attending Physician:	Tax ID No:

_____ _____
Signature of Attending Physian Date signed (mm/dd/yy)

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.