



P.O. Box 692350 • Stockton, CA 95269-2350 • Phone 800-417-8923

EMPLOYEE ID NUMBER

____ - _____

EMPLOYEE SOCIAL SECURITY NUMBER

____ - ____ - _____

WEEKLY DISABILITY BENEFIT

Part 1 — TO BE COMPLETED BY EMPLOYEE

Benefits cannot be determined until all items are completed in full

1. Name _____ (Please Print) Date of Birth _____

Address _____ (No. and Street) (City) (State) (Zip Code)

Employer's Name _____ Occupation _____

2. Is this condition caused by employment? Yes No

3. Does claim involve an injury? Yes No Was injured person at work? Yes No

Date and time of Injury _____

How did injury happen? _____

4. If disabled, show first date you were unable to work. Date _____ Hour _____ A.M. P.M.

Have you returned to or are you able to work now? Yes No If Yes, Date _____

List any dates you worked between the first date above and today's date. From _____ To _____

MEDICAL HISTORY RELEASE AUTHORIZATION

"I authorize any medical information relating to this claim to be disclosed to and acquired by the Administrator of this Plan and such agents of the Administrator as are necessary to process this claim. Such information may be disclosed by a health care provider or other plan administrator. This authorization shall remain valid until the claim is paid provided such information shall be retained only for such longer period as required by law.

I agree that a photographic copy of this authorization shall be as valid as the original."

Date _____ Signature _____

Part 2 — TO BE COMPLETED BY EMPLOYER

Name of Employee _____ Name of Employer _____

First Full Day Unable to Work _____ Address _____

Date resumed work _____ City _____ State, Zip Code _____

Date expected to resume work _____ Phone Number _____

Date terminated _____ Signature of the person responsible for employment records _____

Was Employee treated by the company doctor? No Yes Date _____ Title _____ Date _____

Has Employee worked at all between the above dates? No Yes From _____ To _____

PHYSICIAN MUST COMPLETE BACK PAGE