SHORT TERM DISABILITY CLAIM STATEMENT

PART 1: TO BE COMPLETED BY CLAIMANT

Male ❍ Female ❍

NAME | SOCIAL SECURITY NUMBER | DATE OF BIRTH

STREET ADDRESS | CITY | STATE | ZIP

HOME PHONE | EMAIL ADDRESS

Type of Disability: ❍ Accident ❍ Illness ❍ Pregnancy

Describe how and where accident occurred or list symptoms of illness and diagnosis:____________________

Is the employee receiving any other income related to this disability? ❍ YES ❍ NO

Source: ____________________ Amount: ____________________ Per: ❍ week ❍ month

Is your accident or illness work related? ❍ YES ❍ NO If yes, please explain:____________________

DATE SYMPTOMS FIRST APPEARED | DATE FIRST TREATED | DATE FIRST UNABLE TO WORK

PHYSICIAN(S) NAME | ADDRESS

I understand and acknowledge that any provider of medical services, insurance company, consumer reporting agency, Social Security Administration, governmental agency, educational institution, law enforcement agency or employer having medical information with respect to any physical or mental condition, rehabilitation and other non-medical information or me may give SET, Inc., or its representatives, any and all such information. I understand SET, Inc. may discuss my limitations/restrictions with current or prospective employers as they relate to accommodations and possible return to work.

I UNDERSTAND the information obtained by use of this acknowledgement will be used by SET, Inc. to determine the eligibility for benefits. I know that a photographic copy of this acknowledgement shall be as valid as the original. I agree this acknowledgement shall be valid for the duration of the claim.

If I receive a disability benefit greater than that which I should have been paid, I understand the insurance company has the right to recover such overpayments from me, including the rights to reduce or adjust future benefits, if any.

SIGNATURE | DATE

PART 2: TO BE COMPLETED BY EMPLOYER

CLAIMANT'S NAME | DATE EMPLOYED | EFFECTIVE DATE OF PLAN

Has claimant made prior claim for benefits? ❍ Yes ❍ No If yes, when?____________________

Date last worked _____/_____/_____ Number of hours worked that day_____ Work schedule at time of disability_____days/week _____hours/day

OCCUPATIONS, TITLE OR POSITION

DESCRIBE THE CLAIMANT'S JOB DUTIES (IF AVAILABLE, ATTACH A FORMAL JOB DESCRIPTION)

Basic weekly earnings as of last day worked $____________________ Weekly benefit amount $____________________

Is claimant eligible for Workers' Compensation as a result of this disability? ❍ Yes ❍ No ❍ Currently disputed

Has claimant returned to work? ❍ Yes ❍ No If yes, on what date? _____/_____/_____ ❍ With restrictions ❍ Full capacity

Employee's Contract Year____________________ ❍ School year ❍ Twelve month

Available sick & vacation days____________________ If they have available sick & vacation days, do you require them to be used? ❍ Yes ❍ No

If yes, the available sick & vacation days need be used from_____/_____/_____ thru_____/_____/_____ Allow days to be freezed? ❍ Yes ❍ No

EMPLOYER'S NAME | ADDRESS | CITY | STATE | ZIP

PHONE | FAX | EMAIL

YOUR NAME AND TITLE | DATE | SIGNATURE

THE PATIENT MUST PAY ANY COSTS FOR COMPLETION OF THIS FORM

PART 3: TO BE COMPLETED BY ATTENDING PHYSICIAN *If necessary, attach separate sheet*

HISTORY & PROGNOSIS

PATIENTS NAME ________ PATIENTS DATE OF BIRTH ________

Patient's symptoms result from *(check all that apply)*:
❍ Illness ❍ Auto accident ❍ Other accident ❍ Pregnancy ___/___/___ (expected/actual delivery date) Type of delivery:________________

Date symptoms first appeared ___/___/___ Please fully describe the patients limitations:________________

When did these limitations apply (date of disability)?
Began ____/____/____ Anticipated reduction ____/____/____ Anticipated return to work date ____/____/____

Hospital name ________________ Confinement dates ____/____/____ thru ____/____/____

DIAGNOSIS

Diagnoses with ICD9/ICD10 Codes: List in descending order (including any complications). Please go to the appropriate assessment section and elaborate.

LIST ICD9/ICD10 CODE ________

SUBJECTIVE SYMPTOMS ________

OBJECTIVE FINDINGS ________

Attach medical records which document the above diagnosis (Include results/copies of x-rays, lab tests, EKGs, MRIs, and Scans). Do you believe a legal guardian or conservator should be appointed for this patient? ❍ Yes ❍ No

TREATMENT

First visit for this condition ___/___/___ Most recent visits ___/___/___ Most recent comprehensive exam ___/___/___

Describe the treatment program and give dates of any surgery, medications (dosage/administrations routine), physical therapy, or psychotherapy.

Frequency of treatment: ❍ Weekly ❍ Monthly ❍ Other *(Specify)* ________________

FUNCTIONAL ASSESSMENT

❍ Class 1: No limitation; capable of heavy work* - exert 50-100# occasionally and/or 25-50# force frequently.
❍ Class 2: Medium activity* - exert occasionally 20-50# force and/or 10-25# force frequently.
❍ Class 3: Slight limitation; capable of light work* - exert occasional 20# force and/or up to 10# force frequently.
❍ Class 4: Moderate limitation; capable of sedentary* - clerical or administrative work - occasional 10# force, mostly sitting.
❍ Class 5: Severe limitation; incapable of minimal activity or sedentary work* ❍ Bed confined ❍ House confined
❍ Remarks________________

*As defined by the U.S. Department of Labor's Federal Dictionary of Occupational Titles

PSYCHIATRIC ASSESSMENT

List the patient's DSM-IV Axes: I ________ II________ III ________ IV ________
V ________ Date___/___/___ Highest GAF in past year________ Date ___/___/___

PLEASE DEFINE STRESS AS IT APPLIES TO THIS PATIENT ________

LIST WHAT STRESS AND PROBLEMS IN INTERPERSONAL RELATIONS HAS PATIENT HAD ON THE JOB ________

PLEASE FULLY DESCRIBE THE PATIENT'S LIMITATIONS ________

REHAB

Is patient a candidate for vocational rehabilitation services? ❍ Yes ❍ No Explain:________________

DESCRIBE ANY JOB MODIFICATIONS THAT WOULD AID YOUR PATIENT IN PERFORMING HIS/HER WORK TASKS ________

Has patient reached maximum medical improvement? ❍ Yes ❍ No Explain:________________
If no, when? ____/____/____ ❍ Unknown________________

NAME

PHYSICIAN'S NAME ________ DEGREE ________ SPECIALTY/BOARD CERTIFICATION ________

ADDRESS ________ PHONE ________ FAX ________

SIGNATURE ________ DATE ________ PHYSICIANS EIN OR SSN ________

Send completed form to: SET, Inc. | Attn Life & Disability Claims
415 W. Kalamazoo St. Lansing, MI 48933-2079 | Fax (517) 482-4181

REV. 5/23/16

Phone: (800) 292-5421 | Email: customerservice@setseg.org