



DISABILITY INCOME BENEFITS

Claim and Disability Status Form

INSTRUCTIONS:

1. Employee must complete, sign and date Employee Statement.
2. Employee must have their employer's Personnel Department Representative complete, sign and date Employer Statement.
3. Be sure to complete pages 1-4 of this form.

EMPLOYEE STATEMENT

1. Name of employee _____ Title _____ Date of birth ___/___/___
2. Sex ____ Social Security # _____ Department _____ Phone (____) _____
3. Address of employee _____ City _____ State _____ Zip _____
4. When did the accident happen or illness begin? ___/___/___ 5. Is this condition related to employment? Yes No
6. Date last worked ___/___/___ 7. Date resumed work ___/___/___ 8. If not back to work, when will you probably return? ___/___/___
9. If injured, how and where did injury occur? _____

10. Are you or will you be receiving wage-replacement benefits from any other insurer? Yes No
 If yes, name of insurer _____ Contact person and phone _____

11. List all treating physicians:
 Name _____ Phone _____ Name _____ Phone _____
 Name _____ Phone _____ Name _____ Phone _____

12. Did you seek treatment at a hospital emergency room? If so, when and where? _____

13. Beneficiary Name _____
 Address _____ City _____ State _____ Zip _____

Employee signature _____ Date _____

EMPLOYER STATEMENT

1. Date hired ___/___/___ 2. Date last worked ___/___/___ 3. Date work resumed ___/___/___
4. Hourly pay rate \$ _____ Effective date of pay rate ___/___/___ 5. Class _____
6. Is this claim being filed for Accidental injury or Illness? 7. Is this condition work related? Yes No
8. Has the employee filed for Worker's Compensation benefits? Yes No
9. Regularly scheduled work week = _____ hours

Remarks _____

Employer _____

Contact Person _____ Phone (____) _____

Address _____ City _____ State _____ Zip _____

Date _____ By _____ Title _____

Return signed original to: LGC HEALTHTRUST. Employee and employer should retain a copy.



DISABILITY INCOME BENEFITS

Agreement Concerning Benefits Short-Term Disability Plan

INSTRUCTIONS: Employee must complete, sign and date this agreement as the claimant and have it witnessed and signed.

Claimant: _____

Employer: _____

Address: _____

Date of Disability: _____

In consideration of the **[advance]** payment of weekly income benefits made to me by my employer under my employer’s Short-Term Disability Plan (the “Plan”), administered by Local Government Center HealthTrust, LLC (“LGC HealthTrust”), I represent, acknowledge and agree that:

1. I have not received and am not currently receiving any other benefits or payments for loss of income due to my disability from Workers’ Compensation, automobile insurance, individual disability or other insurance, any state or federal disability income or unemployment benefit law or similar law, or any other type or source of wage replacement;
2. My benefits under the Plan will be reduced by any such benefits or payments for loss of income for which I may be eligible while disabled, and that I will not be eligible for any benefits under the Plan for any period that I am eligible to receive benefits from Workers’ Compensation;
3. If I receive any such benefits or payments during my disability, regardless of the source or amount, I will immediately notify my employer and LGC HealthTrust of such benefits or payments and will pay back all amounts paid to me by the Plan which exceed the amount actually due to me under the terms of the Plan;
4. To the extent benefits are paid to me pursuant to the terms of the Plan, my employer and LGC HealthTrust will be subrogated and succeed to any recovery or right of recovery I might have against (i) any third party who is responsible for causing my disability, or (ii) any workers’ compensation carrier, other insurer or other provider of income replacement benefits which are paid or payable to me due to my period of disability; and
5. I have an obligation to inform my employer and LGC HealthTrust of any such income replacement benefits or payments that may be available and to provide such information and assistance, and execute such documents, as LGC HealthTrust may require to assist in the recovery of such benefits or payments.

I understand that my employer and LGC HealthTrust, in reliance on the above statements and promises, will agree to advance benefit payments to me from the Plan.

Witness

Claimant

Address

Address

Date

Date

Return signed original to: LGC HEALTHTRUST. Employee and employer should retain a copy.



DISABILITY INCOME BENEFITS

Patient's Authorization to Release Information

INSTRUCTIONS: 1. Employee must complete, sign and date this release. 2. Employee must provide a copy to physician.

I authorize my medical care provider(s) to disclose to Local Government Center HealthTrust LLC, any information relating to my current medical condition necessary to process my claim for disability income benefits under my employer's Short-Term Disability Plan.

With respect to my authorization to release my medical information, I understand and acknowledge that:

I can revoke this authorization at any time by giving my written revocation to my physician or other medical care provider.

My healthcare treatment by my physician or other medical care provider will not be affected if I refuse to sign this form.

I am authorizing disclosure of information protected under federal privacy law and that the information, once disclosed, could be subject to re-disclosure by the recipient and no longer be protected by federal privacy law.

If I do not revoke it, this authorization will expire 18 months from the date that I sign it.

I am entitled to receive a signed copy of this authorization and a copy will serve as an original.

I acknowledge that this authorization is subject to the terms set forth above, all of which I have read and understand.

Name of Patient _____

Address _____

City _____ **State** _____ **Zip** _____

Date of Birth ___/___/___ **Social Security Number** _____

Patient's Signature _____ **Date** _____

Return signed original to: LGC HEALTHTRUST. Employee and Physician or other Medical Care Provider(s) should retain a copy.



DISABILITY INCOME BENEFITS

Physician's Statement

INSTRUCTIONS: Physician must complete, sign and date this form.

Patient Name: _____ Date of Birth: _____

1. Is this condition work related? Yes No

2. Diagnosis and Diagnosis Code _____

3. (a) Date of first treatment ___/___/___ (b) Date of most recent treatment ___/___/___ (c) Date of delivery ___/___/___

4. The patient has been totally and continually disabled (unable to work) from ___/___/___ through ___/___/___

5. Assessment:

(a) Describe the patient's current physical and mental limitations and work activity restrictions: _____

(b) How long will the described limitations impair the patient? _____

(a) Describe current treatment: _____

(d) Will the patient require surgery? _____ If so, date of surgery ___/___/___

6. Prognosis:

(a) When do you expect a fundamental or marked change in the patient's condition? _____

(b) When do you anticipate the patient can return to work? _____

(c) Date of next follow-up visit ___/___/___

Physician's name (please print) _____ M.D. Date _____

Physician's signature _____ Phone _____

Address _____

City _____ State _____ Zip _____

Return signed original to: LGC HEALTHTRUST. Employee, Employer and Physician or other Medical Care Provider(s) should retain a copy.