


**EMPLOYEE'S STATEMENT**

Employee Name (Last) (First) (Initial)			Employer Name			Group Number		
Employee Address				Date Employed		Employee Birthdate		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
City, State, Zip Code				Social Security Number			Home Telephone No.	
Did your work cause this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No				Has a claim been filed with Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Name and address of any other insurance carrier providing benefits for this claim (including Motor Vehicle and Worker's Compensation):						Has your Worker's Comp claim been accepted? <input type="checkbox"/> Yes <input type="checkbox"/> No If your claim has been denied, please attach a copy of the Worker's Compensation Denial.		
First Full Day Unable to Work		Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	If partially disabled, first day unable to work full-time		Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Date you expect to return to work		If you have returned to work, please give date: Full-Time: or Part-Time: # of hours per day:
IF CLAIM IS FOR AN INJURY COMPLETE THIS SECTION	Date of injury		Time <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.	Were you at work when injured? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, for whom?		
	How did injury happen?							
	Where were you when you were injured?							
<b>I certify that the above statements are true and complete to the best of my knowledge and belief.</b>								
Employee Signature 						Date		

**INSURANCE FRAUD WARNING** – Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

**EMPLOYER MUST CERTIFY FOR DISABILITY**

Date Employed		<input type="checkbox"/> Hourly <input type="checkbox"/> Salary	Current Salary \$		Job Title		Regular Scheduled Hours Per Week		Group Number		
Is this disability the result of occupational disease or injury arising in the course of employment? <input type="checkbox"/> Yes <input type="checkbox"/> No					If related to employment, has a claim been filed with Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the claim been accepted: <input type="checkbox"/> Yes <input type="checkbox"/> No Denied: <input type="checkbox"/> Yes <input type="checkbox"/> No						
First Day Unable to Work			Date Resumed Work		Date Expected to Resume Work <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time			If employee is released to light or modified duty, can you accommodate?			
List Primary Job Duties						How physically challenging are the job duties? <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy					
Is the employee receiving sick pay? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Sick Pay Began		Date Sick Pay Ended		Date Sick Pay Expected to End		Amount of Weekly STD Benefit \$			
What is the amount of weekly sick pay received per week? \$				What percent of salary does paid sick leave represent? %				Employee Class			
Is a buy-up option included in this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No Did the employee elect the buy-up? <input type="checkbox"/> Yes <input type="checkbox"/> No				If any portion of the premium is paid by the employee, is it paid with pre-tax or post-tax dollars? <input type="checkbox"/> Pre-tax <input type="checkbox"/> Post-tax				What percent of STD premium is paid by employer? %			
Company Name				Address (Street, City, State, Zip Code)							
Telephone Number		Completed by				Title		Date			

**Page 2 must be also be completed by employee and physician.**

**EMPLOYEE COMPLETE THIS SECTION BEFORE  
REFERRING FORM TO YOUR PHYSICIAN**

Employee Name (Last)	(First)	(MI)	Social Security Number	Employer Name	Group Number
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The following authorization will be used to obtain additional information (if necessary) concerning this claim.


**Authorization for Release of Information**

**Persons or Institutions:** This authorizes you to give Regence Life and Health Insurance Company (RLH), its representatives, or persons performing business or legal services on behalf of RLH any information, data or records you have regarding my medical history and treatment (including records pertaining to psychiatric, drug or alcohol use, relating to sexually transmitted diseases or HIV/AIDS testing information and any medical condition I may now have or have had), and any information, data or records regarding my Social Security, FICA earnings history, Worker's Compensation, state disability, earnings and employment history needed to evaluate my claim for disability benefits.

I understand that any information obtained pursuant to this authorization will be used only to evaluate my claim and may be transferred to any organization or person employed by or representing RLH to assist with this purpose. This authorization is valid for the duration of my claim. I understand that I have the right to request and receive a copy of this authorization. A photocopy of this authorization is as valid as the original.

Employee Signature 	Date
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**PHYSICIAN'S STATEMENT OF DISABILITY  
To Be Furnished Without Expense To The Insurance Company**

Patient Name		Age	Address		
Diagnosis and Concurrent Conditions (ICD-9)				Nature of Surgical Procedure, if any	
Is condition due to injury or illness arising out of employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has a claim been filed with a Worker's Comp carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please identify company		If condition is due to pregnancy, what is the expected date of delivery?	Expected type of delivery?
Date symptoms first appeared or accident happened		Date patient first consulted you for this condition		Is patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Give Treatment Dates – Office	ER	Outpatient Facility		Hospital – Admission	Discharge
Was patient treated by another provider for this disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, show dates, name and address of Provider					
_____					
_____					
Was patient continuously disabled (unable to work) in their own occupation? Full-time: <input type="checkbox"/> Yes <input type="checkbox"/> No   Part-time: <input type="checkbox"/> Yes <input type="checkbox"/> No			From	Thru	
If still disabled, date patient should be able to return to work: _____				Own Occupation? <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	
_____				Any Occupation? <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	
Describe impairments, if any, precluding patient from returning to regular occupation OR provide information regarding job modification which would allow patient to return-to-work:					
To Full-time:					
_____					
_____					
To Part-time or light-duty:					
_____					
_____					
Print or Type Physician's name and degree(s)			Attending Physician's Signature		
Physician's Address (Street)					
(City, State, Zip Code)			Date		
			Telephone Number		