

PINAL COUNTY SHORT TERM DISABILITY FORM

(RETURN TO PINAL COUNTY HUMAN RESOURCES UPON COMPLETION)

ALL SECTIONS OF THIS FORM MUST BE COMPLETED BY THE PERSONS INDICATED. SECTIONS I AND II MUST BE COMPLETED AND THEN THE FORM IS TO BE SENT TO PINAL COUNTY HUMAN RESOURCES TO COMPLETE AND RETURN TO AMERIBEN/IEC GROUP.

FOR QUESTIONS CONTACT:

AMERIBEN/IEC GROUP
P.O. Box 7186
BOISE, ID 83707
1-877-955-1548
FAX: 208-424-0595

SECTION I (EMPLOYEE'S STATEMENT)

EMPLOYEE NAME:		SOCIAL SECURITY NUMBER OR MEMBER ID#			
MAILING ADDRESS:	STREET	CITY	STATE	ZIP	
HOME PHONE NUMBER:		CELL PHONE NUMBER:			
DISABLING CONDITION:					
DATE DISABILITY BEGAN:		LAST DAY WORKED:			
IF CAUSE OF DISABILITY IS AN ACCIDENT OR INJURY, PLEASE PROVIDE THE DATE, PLACE AND BRIEF DETAILS:					
DID IT HAPPEN AT WORK? YES _____ NO _____					
IF DISABILITY IS DUE TO AN ILLNESS, PLEASE DESCRIBE ILLNESS AND WHY IT PREVENTS YOU FROM WORKING:					
IF DISABILITY DUE TO PREGNANCY; WHAT IS EXPECTED DELIVERY DATE:					
NAME OF PHYSICIAN YOU ARE CURRENTLY SEEING:					
PHYSICIAN NAME:		TELEPHONE:			
PHYSICIAN ADDRESS:	STREET	CITY	STATE	ZIP	
DATE YOU FIRST CONSULTED PHYSICIAN FOR THIS CONDITION:					
HAVE YOU RETURNED TO WORK?		IF YES, DATE YOU RETURNED:			
ARE YOU RECEIVING ANY OF THE FOLLOWING?					
DISABILITY BENEFITS PROVIDED BY NO FAULT AUTO INSURANCE? YES <input type="checkbox"/> NO <input type="checkbox"/>					
SOCIAL SECURITY BENEFITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					
REHABILITATION INCOME? YES <input type="checkbox"/> NO					
ANY SALARY, WAGES, COMMISSION, OR SIMILAR COMPENSATION PAYMENTS? YES <input type="checkbox"/> NO <input type="checkbox"/>					
LOSS OF TIME BENEFITS PROVIDED BY ANY OTHER GROUP INSURANCE CONTRACT, INCLUDING WORKERS COMPENSATION? YES <input type="checkbox"/> NO <input type="checkbox"/>					
I HEAR BY CERTIFY THAT THE FOREGOING STATEMENTS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND HEREBY AUTHORIZE ALL DOCTORS, HOSPITALS OR ANY OTHER PROVIDER WHO TREATS ME, TO FURNISH ALL INFORMATION AND RECORDS TO AMERIBEN/IEC GROUP IF REQUESTED A COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS VALID AS THE ORIGINAL.					
EMPLOYEE SIGNATURE: _____			DATE: _____		

SECTION II (PHYSICIAN'S STATEMENT)

PRIMARY DIAGNOSIS:

DATES SEEN:

DESCRIPTION OF TREATMENT

PROGNOSIS

DATES THE PATIENT WILL BE UNABLE TO PERFORM HIS/HER REGULAR AND CUSTOMARY OCCUPATION:

FROM: THROUGH

HAS THE PATIENT BEEN RELEASED TO WORK?

IF YES, WHEN?

LIST ANY RESTRICTIONS:

PHYSICIAN'S FULL NAME (TYPE OR PRINT):

PHYSICIAN'S TAX ID NUMBER:

PHONE NUMBER:

ADDRESS:

ATTENDING PHYSICIAN'S SIGNATURE:

DATE:

SECTION III (THIS SECTION TO BE COMPLETED BY AN AUTHORIZED PINAL COUNTY HUMAN RESOURCE REPRESENTATIVE)

DATE OF EMPLOYMENT:

DATE LAST WORKED:

ANNUAL SALARY AS OF JANUARY 1 OF THE PLAN YEAR:

SICK, VACATION AND COMP TIME EXHAUSTED ON:

REMARKS:

PINAL COUNTY HUMAN RESOURCE REPRESENTATIVE:

SIGNED:

DATE