

Name Address Administration Services

## Weekly Disability Verification Required to receive disability benefits Page 1 of 2

Date:

Important: Failure to return this form promptly may result in the delay of payment for disability benefits.

Part 1-To be completed by EMPLOYEE

Date of Birth	Health Care Identification Number (HCID):
Daytime Phone number	Hamber (Helb).
Date and time of the accident or onset of disability.	
Where did the accident or the onset of disability occur?	
Is this condition/injury related to employment?	
If due to an accident, please provide details of how the accident occurred.	
First date you were unable to work?	Standard and control of the standard and
Have you returned to work? If yes, please provide the exact date	. I'all according on
List any dates you have worked between the first day you were unable to work and the date on this form.	
strator as are necessary to process this claim. Such information r shall remain valid as long as I am disabled and required to provic valid as an original signature. Employee Signature:	may be disclosed by a health care provider or other plan administrator. This authorization de weekly disability verification(s). I agree that a photocopy of this authorization shall be
shall remain valid as long as I am disabled and required to provice valid as an original signature.  Employee Signature:  Part 2-	may be disclosed by a health care provider or other plan administrator. This authorization de weekly disability verification(s). I agree that a photocopy of this authorization shall be -To be completed by PHYSICIAN  Weekly Disability Benefits; follow-up verification may be requested.
hall remain valid as long as I am disabled and required to providation at an original signature.  Imployee Signature:  Part 2-  This information is required to initiate V	de weekly disability verification(s). I agree that a photocopy of this authorization shall be determined by PHYSICIAN
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YOUR PARTNER IN HEALTHCARE SOLUTIONS

Phone: 800-417-8923 Post Office Box 80 Stockton, CA 95201-3080



Weekly Disability Verification Required to receive disability benefits Page 2 of 2

Administration Services

**Important:** Failure to return this form promptly may result in the delay of payment for disability benefits.

	To be completed	by PHYSICIAN (Continued)			
Have any surgical procedures been performed? If so, please list.	Surgery Date(s)	Type of Surgery Performed	If hospitalized fo	If hospitalized for this surgery:	
			Date Admitted	Date Discharged	
				draft forestation	
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		No est	esco e ivo q erest, mal	organis og egt til	
Other than the surgical procedures listed above, has this patient been hospitalized? If so, please list.	R	Reason for Hospitalization		Date Discharged	
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Other medical, non-surgical treatments?	NATIONAL DINA	Technology and are a species			
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	Vorificat	tion by Physician			
	Vernical	tion by Fifysician	Date:	MCD TO STORY	
Physician's Signature					
Physician's Name (Please Print)		70000			
Degree/Practice Speciality			fara, en la como de se	young and any	
Physician's Office Address		esseur enede i	grave stilling proming sounds	Tal Account with	
Physician's Office Telephone Number		September 1			
License Number					
Federal Tax ID Number					

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