



Send Completed Form To:
 Associated Mutual
 5800 Foremost Drive, Suite 207
 Grand Rapids, MI 49546
 Fax (616) 808-2899

Short Term Disability Claim Statement

Part 1 - To be completed by the Claimant (please print or type).

Name		Social Security Number		Date of Birth	
Street Address		City	State	Zip Code	Home Phone ()
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Type of Disability: <input type="checkbox"/> Accident <input type="checkbox"/> Illness <input type="checkbox"/> Pregnancy		E-mail Address		

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

Are you receiving or eligible to receive Workers' Compensation, Social Security disability benefits, or pension benefits? (Describe) Yes No

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
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Physician(s) name and 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 of me may give MEBS/Associated Mutual, or its representatives, any and all such information. I understand MEBS/Associated Mutual 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 MEBS/Associated Mutual 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 the Employer

Claimant's Name		Date Employed	Effective date of plan	Has claimant made prior claim for benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> When? / /
Date last worked ___/___/___	Work schedule at time of disability Number of hours worked that day ___ 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently disputed
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Percentage of premium paid by: Claimant _____% Employer _____%

Are claimant premium contributions made under Section 125 of the Internal Revenue Code (i.e. a Cafeteria Plan paid with pre-tax dollars?)
 Yes No

Has claimant returned to work? Yes No	Employee's Contract Year:	Remarks:
If "Yes", on what date ___/___/___ <input type="checkbox"/> With restrictions <input type="checkbox"/> Full capacity	<input type="checkbox"/> School Year <input type="checkbox"/> Twelve Month	

Employer's Name	Address	
Telephone Number ()	Fax Number ()	E-mail Address

Your Name and title	Date	Signature
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