

SHORT TERM DISABILITY BENEFITS CONTINUATION CLAIM FORM

INSTRUCTIONS FOR FILING A CLAIM FOR SHORT TERM DISABILITY BENEFITS

- Employee completes Part A below and forwards to the physician.
- Physician completes Part B on reverse side and returns form to employee.
- Employee should send completed form to AmeraPlan, Inc. at address listed below.

PART A: TO BE COMPLETED BY EMPLOYEE

1. Employer's Name:	2. Employer's Plan/Branch No.:
3. Name of Employee	4. Social Security Number
5. Address	
6. Have you returned to work? Yes <input type="checkbox"/> No <input type="checkbox"/>	7. If yes, give date:
8. Are you still disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>	9. If yes, give date you expect to return to work:
9. Have you filed for state unemployment? Yes <input type="checkbox"/> No <input type="checkbox"/>	10. Have you filed for Workers' Compensation benefits? Yes <input type="checkbox"/> No <input type="checkbox"/>

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned physician to release to Employee Benefit Strategies any information acquired in the course of my examination or treatment that may be required to establish the validity of this claim. I further authorize the physician to disclose any personal or claim information required for medical case study or review. A photo copy of this authorization shall be considered as effective and valid as the original.

Signature: _____

Date: _____

PART B: TO BE COMPLETED BY THE ATTENDING PHYSICIAN

1. Diagnosis and concurrent conditions:	
2. Is condition due to injury or sickness arising out of patient's employment? Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. Dates of service (if form previously submitted, show only dates since last report):	
4. Date symptoms first appeared or accident happened:	5. Is patient still under your care for this condition? Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Patient was continuously totally disabled (unable to work) From: _____ Through: _____	7. If still disabled, date patient should be able to return to work:

Physician's Name (Print)		Degree	Telephone
Street Address		City/Town	State/Province
Zip Code			
Doctor's Tax Account No.	Individual Practitioner - Social Security No.		
	All Others - Employer Identification No.		
Physicians' Signature: _____		Date Completed: _____	

PHYSICIAN: Please return completed form to:

Ameraplan, Inc.
3001 West Big Beaver Road, Suite 320,
Troy, MI 48084

Phone: 800.221.4254
FAX: 248.643.9401