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Group Disability Plan Claim Form

(please print in ink or type)

Note: Every item must be completed before claim can be processed!

Employer Section

Employee Name: _____ **SSN:** _____ **DOB:** _____

On Form W-4: How many withholding allowances claimed: _____ **Single** **Married**

Date the employee was last active at work: _____ **Resumed work:** _____

Has employment been terminated? **Yes** **No**

Is this disability due in any way to the employee's occupation? **Yes** **No**

Is this disability covered by Worker's Compensation? **Yes** **No**

Signature of Employer Representative

Date

Name of Employer Representative

Telephone Number

Employer Name

Group Number

Physician Section

Disability a result of: **Illness** **Date of First Symptom:** _____

Injury **Date of Accident:** _____

Pregnancy **Date of LMP:** _____

Date(s): **First consulted you for this condition** _____

Employee able to return to work _____

Total Disability _____ **to** _____

Partial Disability _____ **to** _____

Has Employee ever had same or similar symptoms? **Yes** **No**

Reason for Disability/Condition Diagnosed:

Restrictions:

Signature of Attending Physician

Degree **Date** _____

Name of Attending Physician

Telephone Number

Street Address

City, State, Zip Code