MUNICIPAL HEALTH BENEFIT FUND
PO Box 188
North Little Rock, AR 72115

Disability Income Claim Form

Employee Instructions:

1. This form is to be filed as soon as you become disabled and qualify for disability benefits.
2. Complete the "Statement of Employee" below.
3. Your Physician must complete the "Physician's Statement of Disability" on the reverse side.
4. **Please note that claims will not be considered for more than four (4) weeks at a time. An updated Physician Statement will be required for benefits to continue.**
5. Return this form to the address above.
6. Be sure to notify MHBF as soon as you return to work.

Statement of Employee:

_____ _____
Employee Name Telephone Number

_____ _____ _____ _____
Occupation Date of Birth Social Security Number

When did you become wholly unable to work? _____ _____ _____ _____ AM/PM
Date Time

Is disability due to an _____accident or _____illness? If an accident, please describe, including date and

place accident occurred:_____

If an illness, when did symptoms first appear? _____

Have you been hospitalized? _____Yes _____No If so, when? From _____ _____ _____ To _____ _____ _____

Please list name and location of hospital: _____

Did disability result from your employment? _____Yes _____No

If you have other disability insurance coverage, please list the name(s) of the carrier(s), along with policy numbers:

_____ _____
Company Name Policy Number

_____ _____
Company Name Policy Number

I attest that these statements are true and complete to the best of my knowledge. I authorize any insurer, physician or hospital to disclose any information regarding my insurance coverage or medical history.

_____ _____ _____ _____
Employee Signature Date

Address:_____
City State Zip

Physician Statement of Disability:

1. _____ _____ _____ _____ _____ _____
   Patient Name | Date of Disability | Date of Exam
2. Diagnosis, including any complications:_____
   _____
3. Objective finding, including x-rays, labs, and/or any clinical findings:_____
   _____
4. Is Patient partially disabled: ◯ Yes ◯ No Is Patient temporarily totally disabled: ◯ Yes ◯ No
   Is Patient able to perform any other work: ◯ Yes ◯ No Describe:_____
   What job duties is patient unable to perform: _____
5. Will patient recover sufficiently to return to their regular duties: ◯ Yes ◯ No
6. Patient may return to regular job within: ◯ 1 week ◯ 1- 2 weeks ◯ 2-4 weeks ◯ Never
7. Patient may return to other work within: ◯ 1 week ◯ 1- 2 weeks ◯ 2-4 weeks ◯ Never
8. Is Patient a candidate for Social Security Disability: ◯ Yes ◯ No
   (permanently disabled)
9. **List next appointment date:** _____ _____ _____ ***(Claim is not payable beyond this date.)***

Be sure to send in updated claim form for consideration if disability will last beyond the above date

_____ _____ _____
Print Physician Name | Degree | Specialty

_____ _____ ___/_____ _____ _____
Address | City | St | Zip | Telephone No.

_____ _____ _____ _____
Signature | Date

When you return to work, your employer must fill out the following information:

Date returned to work: _____ _____ _____

_____ _____
Print Employer Representative | Print Title

_____ _____ ___/_____ _____ _____
Address | City | St | Zip | Telephone No.

_____ _____ _____ _____
Signature | Date

06/09/08 rev

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