DISABILITY CLAIM FORM

LIBERTY NATIONAL LIFE INSURANCE COMPANY
POLICY BENEFITS DEPARTMENT • P.O. BOX 8080 • MCKINNEY, TX 75070-8080
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PART A - DISABILITY FORM TO BE COMPLETED BY THE EMPLOYER'S AUTHORIZED REPRESENTATIVE

1. Employee Name Occupation Employer Name

_____

2. Employee's Present Status: ☐ Working Full-Time ____ Hours per week ☐ On Vacation

☐ Disabled/unable to work since ____/____/_____ ☐ On Authorized Leave of Absence as of ____/____/_____

☐ On Temporary Lay-off as of ____/____/_____ ☐ Retired as of ____/____/_____

3. Date Employee Returned to Work ____/____/_____ Was Employee Full-Time as of Disability date ☐ Yes ☐ No

4. Nature of Employee's Disability _____ Weekly Wage Amount $_____._____

5. Signature of Employer's Authorized Representative Date Title

_____ ___/___/_____ _____

PART B - DISABILITY FORM TO BE COMPLETED BY THE PATIENT'S PHYSICIAN OR SUPPLIER

PHYSICIAN OR SUPPLIER INFORMATION

1. Date of illness (First Symptom) or Injury (Accident) ____/____/_____ **2.** Date first consulted you for this condition ____/____/_____

3. Has patient ever had same or similar symptoms? ☐ Yes ☐ No

4. Name and address of any Physician that referred the patient to you

Name: _____

Address: _____
Street City State ZIP

5. Name and address of Facility where services were rendered (if other than your office)

Name: _____

Address: _____
Street City State ZIP

6. Diagnosis or nature of injury _____

_____

7. Date Patient is able to return to work ____/____/_____

8. Dates of Total Disability: From____/____/_____ To ____/____/_____

9. Dates of Parital Disability: From____/____/_____ To ____/____/_____

10. Was the treatment solely caused by this accident: ☐ Yes ☐ No

11. Signature of Physician or Supplier _____ **13.** ____/____/_____
(I certify that the statements above are true and to the best of my knowledge) Date

12. Tax ID # _____ **14.** NPI # _____