EPIC SPECIALTY BENEFITS

Short-term Disability Claim Form

Employer Statement

1. Employee Name

2. Employee Certificate Number | 3. Policy Number

4. Date of Hire

5. What was the last day worked and number of hours worked that day?

6. A. Was sick time paid? Yes No If yes, please provide date(s) paid. _____ through _____

B. Was vacation time paid? Yes No If yes, please provide date(s) paid. _____ through _____

C. Was salary continuation paid? Yes No If yes, please provide date(s) paid. _____ through _____

7. Did the sickness or injury arise out of or in the course of employment? Yes No

If yes, has a workers compensation claim been filed? Yes No If yes, please provide date(s) paid.
If yes and the claim was denied by your workers compensation carrier, **provide a copy of the DENIAL letter with this claim.**
If no, please explain

8. Is the employee back to work? Yes No Full-Time Part-Time

If yes, please provide the return to work date and copy of physician's return to work notice.

9. If employee is partially disabled, are you able to make reasonable accommodations? Yes No

(example: an employee's job requires daily lifting and carrying of objects in excess of 25 lbs. If the physician releases the employee to return to work with a restriction of lifting and carrying a maximum of 10 lbs. for 3 weeks, can you reasonably accommodate this restriction?)

Note: If you have partial disability coverage and the employee returned to work part-time, you must include the number of hours and days worked as well as the earned wages during the week. This information MUST be sent, faxed, or emailed to EPIC at the end of each week.

10. Employee's average weekly wage? | 11. Employee's average hours per week?

12. Was the employee insured under your prior STD policy? Yes No

If yes, what was the employee's effective date of the prior policy?

13. Job Title

(**IMPORTANT: PLEASE ATTACH JOB DESCRIPTION)**

14. Prior to disability, did you consider your employee able to perform (complete based upon employee's job prior to disability)?

Sedentary Work: Lift 10 lbs. maximum and occasionally carry small objects

Light Work: Lift 20 lbs. maximum and frequently lift/carry up to 10 lbs.

Medium Work: Lift 50 lbs. maximum and frequently lift/carry up to 25 lbs.

Heavy Work: Lift 100 lbs. maximum and frequently lift/carry up to 50 lbs.

Very Heavy Work: Lift in excess of 100 lbs. and frequently lift/carry 50 lbs.

15. Did the employee perform the following tasks (prior to disability)?

	Never	Occasionally (1-33%)	Frequently (34-56%)	Continuously (57-100%)
Push/pull when seated				
Push/pull when standing				
Bend				
Squat				
Crawl				
Climb				
Reach above shoulder level				

16. Assuming an 8-hour workday with two fifteen-minute breaks and ½-hour meal break;
I expect this employee to be able to:
(check the number of hours for each activity)

Sit	1	2	3	4	5	6	7	8	Continuously	With Rest
Stand	1	2	3	4	5	6	7	8	Continuously	With Rest
Walk	1	2	3	4	5	6	7	8	Continuously	With Rest
Alternately sit/stand	1	2	3	4	5	6	7	8	Continuously	With Rest

Comments: _____

FICA TAX WITHHOLDING INFORMATION

17. Indicate employee's Social Security Identification Number as shown on your employment records:

18. Do you contribute 100% of the premium for the employee's short-term disability coverage? Yes No

If no, what percentage of the premium for such coverage is contributed by you _____%; by the employee _____%

19. If the employee contributes to the premium; is the contribution: Pre-Tax Post-Tax

20. Employer Group Name

21. Name and Title of Individual Completing this Form

22. Employer Address City State Zip

23. Employer Telephone | 24. Employer Fax Number

25. Employer E-mail Address

26. Signature of Authorized Representative | Date

MAIL OR FAX FORM TO:

EPIC Specialty Benefits
Attention: Life & Disability Claims
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