SET SEG
School Insurance Specialists

SHORT TERM DISABILITY CLAIM STATEMENT

PART 1: TO BE COMPLETED BY CLAIMANT

Male ☐ Female ☐

NAME | SOCIAL SECURITY NUMBER | DATE OF BIRTH

STREET ADDRESS | CITY | STATE | ZIP

HOME PHONE | EMAIL ADDRESS

Type of Disability: ☐ Accident ☐ Illness ☐ Pregnancy

Describe how and where accident occurred or list symptoms of illness and diagnosis: _____

Is the employee receiving any other income related to this disability? ☐ YES ☐ NO

Source: _____ Amount: _____ Per: ☐ week ☐ month

Is your accident or illness work related? ☐ YES ☐ NO If yes, please explain: _____

DATE SYMPTOMS FIRST APPEARED | DATE FIRST TREATED | DATE FIRST UNABLE TO WORK

PHYSICIAN(S) NAME | ADDRESS

I understand and acknowledge that any provider of medical services, insurance company, consumer reporting agency, Social Security Administration, governmental agency, educational institution, law enforcement agency or employer having medical information with respect to any physical or mental condition, rehabilitation and other non-medical information or me may give SET, Inc., or its representatives, any and all such information. I understand SET, Inc. may discuss my limitations/restrictions with current or prospective employers as they relate to accommodations and possible return to work.

I UNDERSTAND the information obtained by use of this acknowledgement will be used by SET, Inc. to determine the eligibility for benefits. I know that a photographic copy of this acknowledgement shall be as valid as the original. I agree this acknowledgement shall be valid for the duration of the claim.

If I receive a disability benefit greater than that which I should have been paid, I understand the insurance company has the right to recover such overpayments from me, including the rights to reduce or adjust future benefits, if any.

SIGNATURE | DATE

PART 2: TO BE COMPLETED BY EMPLOYER

CLAIMANT'S NAME | DATE EMPLOYED | EFFECTIVE DATE OF PLAN

Has claimant made prior claim for benefits? ☐ Yes ☐ No If yes, when? _____

Date last worked ____/____/____ Number of hours worked that day____ Work schedule at time of disability____days/week ____hours/day

OCCUPATIONS, TITLE OR POSITION

DESCRIBE THE CLAIMANT'S JOB DUTIES (IF AVAILABLE, ATTACH A FORMAL JOB DESCRIPTION)

Basic weekly earnings as of last day worked $_____ Weekly benefit amount $_____

Is claimant eligible for Workers' Compensation as a result of this disability? ☐ Yes ☐ No ☐ Currently disputed

Has claimant returned to work? ☐ Yes ☐ No If yes, on what date? ____/____/____ ☐ With restrictions ☐ Full capacity

Employee's Contract Year_____ ☐ School year ☐ Twelve month

Available sick & vacation days_____ If they have available sick & vacation days, do you require them to be used? ☐ Yes ☐ No

If yes, the available sick & vacation days need be used from____/____/____ thru____/____/____ Allow days to be freezed? ☐ Yes ☐ No

EMPLOYER'S NAME | ADDRESS | CITY | STATE | ZIP

PHONE | FAX | EMAIL

YOUR NAME AND TITLE | DATE | SIGNATURE

THE PATIENT MUST PAY ANY COSTS FOR COMPLETION OF THIS FORM

PART 3: TO BE COMPLETED BY ATTENDING PHYSICIAN *If necessary, attach separate sheet*

HISTORY & PROGNOSIS

PATIENTS NAME _____ PATIENTS DATE OF BIRTH _____

Patient's symptoms result from *(check all that apply)*:
☐ Illness ☐ Auto accident ☐ Other accident ☐ Pregnancy ___/___/___ (expected/actual delivery date) Type of delivery:_____

Date symptoms first appeared ___/___/___ Please fully describe the patients limitations:_____

When did these limitations apply (date of disability)?
Began ____/____/____ Anticipated reduction ____/____/____ Anticipated return to work date ____/____/____

Hospital name _____ Confinement dates _____ thru ____/____/____

DIAGNOSIS

Diagnoses with ICD9/ICD10 Codes: List in descending order (including any complications). Please go to the appropriate assessment section and elaborate.

LIST ICD9/ICD10 CODE

SUBJECTIVE SYMPTOMS

OBJECTIVE FINDINGS

Attach medical records which document the above diagnosis (Include results/copies of x-rays, lab tests, EKGs, MRIs, and Scans). Do you believe a legal guardian or conservator should be appointed for this patient? ☐ Yes ☐ No

TREATMENT

First visit for this condition ___/___/___ Most recent visits ___/___/___ Most recent comprehensive exam ___/___/___

Describe the treatment program and give dates of any surgery, medications (dosage/administrations routine), physical therapy, or psychotherapy.

Frequency of treatment: ☐ Weekly ☐ Monthly ☐ Other *(Specify)* _____

FUNCTIONAL ASSESSMENT

☐ Class 1: No limitation; capable of heavy work* - exert 50-100# occasionally and/or 25-50# force frequently.
☐ Class 2: Medium activity* - exert occasionally 20-50# force and/or 10-25# force frequently.
☐ Class 3: Slight limitation; capable of light work* - exert occasional 20# force and/or up to 10# force frequently.
☐ Class 4: Moderate limitation; capable of sedentary* - clerical or administrative work - occasional 10# force, mostly sitting.
☐ Class 5: Severe limitation; incapable of minimal activity or sedentary work* ☐ Bed confined ☐ House confined
☐ Remarks_____

*As defined by the U.S. Department of Labor's Federal Dictionary of Occupational Titles

PSYCHIATRIC ASSESSMENT

List the patient's DSM-IV Axes: I _____ II_____ III _____ IV _____
V _____ Date___/___/___ Highest GAF in past year_____ Date ___/___/___

PLEASE DEFINE STRESS AS IT APPLIES TO THIS PATIENT

LIST WHAT STRESS AND PROBLEMS IN INTERPERSONAL RELATIONS HAS PATIENT HAD ON THE JOB

PLEASE FULLY DESCRIBE THE PATIENT'S LIMITATIONS

REHAB

Is patient a candidate for vocational rehabilitation services? ☐ Yes ☐ No Explain:_____

DESCRIBE ANY JOB MODIFICATIONS THAT WOULD AID YOUR PATIENT IN PERFORMING HIS/HER WORK TASKS

Has patient reached maximum medical improvement? ☐ Yes ☐ No Explain:_____
If no, when? ____/____/____ ☐ Unknown_____

NAME

PHYSICIAN'S NAME _____ DEGREE _____ SPECIALTY/BOARD CERTIFICATION _____

ADDRESS _____ PHONE _____ FAX _____

SIGNATURE _____ DATE _____ PHYSICIANS EIN OR SSN _____

Send completed form to: SET, Inc. | Attn Life & Disability Claims
1520 Earl Ave., East Lansing, MI 48823 | Fax (517) 482-4181

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Phone: (800) 292-5421 | Email: customerservice@setseg.org