Benefit Administrators, Inc.

COMPLETE THIS FORM AND SEND IT TO
YOUR EMPLOYERS
HUMAN RESOURCE DEPARTMENT

Benefit Administrators, Inc.
1250 Tower Lane
P.O Box 6279
Erie, PA 16512
In Erie, PA: 814-454-0167
Nationwide: 1-800-777-2524

GROUP DISABILITY CLAIM FORM

(PART A) TO BE COMPLETED BY EMPLOYEE

Name of Employee	Social Security # :	Name of Employer

Employee Address **City and State** **Zipcode** **Phone #** **Date of Birth**

Date of Injury or Sickness Began **Day Month Year**

Date Last Worked **Day Month Year**

Date First Treated **Day Month Year**

Nature of Injury or Sickness

If Injured Describe How and Where Did Injury Happen?

PLEASE PRINT:
Attending Physicians Name, Phone Number and Address

Name of Hospital, *If Confined Dates of Confinement*

Are you currently receiving Social Security Benefits?
Yes or No

Is this a Work Related Claim?
Yes or No

Return to Work Date
Day Month Year

AUTHORIZATION TO RELEASE INFORMATION: I authorize any hospital, physician or other party who has attended me or examined me to furnish BAI, Inc. any and all information with respect to any Injury or Sickness and medical history. I agree to update BAI and my Employer of my medical status on a monthly basis (or as needed).

Signature of Employee _____ Date _____

I acknowledge that ( ) has every legal right to coordinate with any Social Security, Motor Vehicle Policy, Unemployment Compensation or any other group disability benefits that I receive **whether presently or retroactively** in addition to the benefits received through ( ). Should I receive any other benefits (as listed above but not limited to) in addition to the benefits received from ( ) Disability Plan, **whether presently or retroactively** it is my full understanding that The Disability Plan has every legal right to recover any amounts paid as a result of coordination of benefits or overpayments recieved. THIS PLAN **REIMBURSES AS A SUPPLEMENT TO SOCIAL SECURITY, MOTOR VEHICLE, UNEMPLOYMENT COMPENSATION AND ANY OTHER GROUP DISABILITY PLAN BENEFITS.**

Signature of Employee _____ Date _____

(PART B) TO BE COMPLETED BY ATTENDING PHYSICIAN

Diagnosis :

Is Patient Still Under Your Care:
Yes ☐ or No ☐

Patient was Continuously Totally Disabled (unable to work)
From : _____ To _____

Patient was Partially Disabled
From : _____ To _____

Dates of Service Patient was Treated:

If Patient is Still Disabled, Please Provide Estimated Return to Work Date :

Physicians Signature : _____ Date : _____

Physicians Address : _____ Phone : _____

(PART C) TO BE COMPLETED BY EMPLOYER ONLY

Name of Employee :		Employee # :	Job Title :
Hourly Benefits:	**Biweekly Benefits :**	Annual Benefit	Tax Status (W4) :
Date Employed :	**Last Date Worked :**	**Disability Begin Date :**	**Returned to Work Date :**

Is this a Work Related Claim?
Yes ☐ or No ☐

Employer Name and Address :

I Certify to the best of my knowledge, the above statements are true and correct :

_____ _____

Date **Signature and Title of the Employer Group Representative**