USHL
US Health and Life

DISABILITY CLAIM STATEMENT

Submit within 90 days
(Non-Occupational Sickness or Accident)

Forward completed form to:
US Health and Life Insurance Company-Disability Claims Department
8220 Irving Road • Sterling Heights, Michigan 48312

Covered Employee Information

Name of Employee:_____ Social Security Number:_____

Street Address:_____ Phone Number: _____

City:_____ State:_____ Zip Code:_____ Date of Birth:_____

Name of Employer:_____ Date of Employment:_____

Address of Employer:_____

Occupation:_____ Local Union No._____

Date of first symptoms: Month_____Day:_____Year:_____Time:_____a.m./p.m.

Date of first treatment: Month_____Day:_____Year:_____Time:_____a.m./p.m.

Date of injury: Month_____Day:_____Year:_____Time:_____a.m./p.m.

How did the accident happen?_____

Where did the accident occur?_____

Did the accident or sickness occur in the course of employment? Yes_____ No_____

If yes, has a claim been filed or will a claim be filed under Workmen's Compensation? Yes_____ No_____

To Whom it May Concern:

I hereby authorize any hospital, physician, employee, insurance company, or other organization to release to US Health and Life Insurance Company or its authorized representative, any and all information you may have with respect to any sickness or injury, including past and present medical history, diagnoses, consultations, prescriptions, examinations, treatment, operative procedures, X-rays and pathological findings. I agree that a photostatic copy of this authorization shall be considered as effective and valid as the original.

Employee Signature:_____ Date:_____Month_____Day_____Year

Employer's Statement

Name of Company:_____Phone Number:_____

Address of Company:_____ City:_____State:_____

Occupation of Employee:_____Weekly Base Salary:_____

Date employee last worked: Month_____Day:_____Year:_____Time:_____a.m./p.m.

Regularly employed and actively working when disabled? Yes_____ No_____

Date employee returned to work: Month_____Day:_____Year:_____Time:_____a.m./p.m.

Was disability caused by employment? Yes_____ No_____

If yes, will claim be filed for Workmen's Compensation? Yes_____ No_____

Employer Signature:_____ Date:_____Month_____Day_____Year

Printed Name:_____Official Title:_____

Attending Physician's Statement

Name of Patient_____Date of Birth:_____

1. Diagnosis and concurrent conditions (if diagnosis code other than "ICDA" used, give name):

   _____

2. Is condition due to injury or sickness

   a. arising out of patient's employment? Yes_____ No_____

   b. arising out of an accident? Yes_____ No_____

   c. or pregnancy? Yes_____ No_____ Date_____
   (if yes, please provided estimated date of delivery)

3. Report of Services

Date of Service	Place of Service*	Description of Surgical or Medical Services Rendered

*Place of Service Codes
O-Doctor's Office IH Inpatient Hospital NH-Nursing Home H-Patient's Home OH-Outpatient Hospital OL-Other Locations

4. Date symptoms first appeared or accident happened: Month_____Day:_____Year:_____

5. Date patient first consulted you for this condition: Month_____Day:_____Year:_____

6. Patient ever had same or similar condition: Yes_____ No_____ If yes, please identify:_____

7. Is Patient still under your care for this condition? Yes_____ No_____

8. Dates Patient was continuously totally disabled (unable to work): From:_____ Through_____

9. Dates Patient was partially disabled: From:_____ Through_____

10. If still disabled, date Patient should be able to return to work: Month_____Day:_____Year:_____

11. If partially disabled, list restrictions:_____

_____
Date Physician's Name (print) Signature Degree Telephone

_____
Street address City/Town State ZipCode

Tax ID Number or Social Security Number_____

US Health and Life Insurance Company • 8220 Irving Road • Sterling Heights, Michigan 48312
In Michigan call 1-586-826-4400