



STATE OF FLORIDA

Group Disability Income Self-Insurance Plan

Return Claim Form to: People First Service Center
Post Office Box 6830
Tallahassee, FL 32314
or Fax to (904) 828-6092

PLEASE PRINT or TYPE

EMPLOYEE'S PART (To prevent delays in processing, all questions must be answered.)

Employee's Last Name, First Name MI	Social Security Number - -	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Employee's Address (Street, City, State, Zip Code)		Date of Birth / /

Area Code + Phone Number () -

1. I have been unable to work because of this disability since: ____/____/____.
 - a. I returned to work on a part-time basis on ____/____/____.
 - b. I returned to work on a full-time basis on ____/____/____.
2. Date of your accident or the date you first noticed symptoms of your illness. ____/____/____
 - a. Is your accident or illness related to your occupation? Yes No
 - b. If Yes, explain: _____
3. Describe how and where accident occurred or describe the first symptoms of your illness. _____
4. Date your were first treated for your illness or injury. ____/____/____

Treated by: Hospital's Name/Address: _____

Doctor's Name/Address: _____
5. Have you ever had the same or similar condition in the past? Yes No

Treated by: Hospital's Name/Address: _____

Doctor's Name/Address: _____

6. Are you receiving, or are you eligible to receive, income from any of the following sources?

Yes	No		Weekly Income	Date Income began/begins	Date ended/ends
		a. Worker's Compensation Benefits			
		b. Retirement or Disability Benefits under the State of Florida Retirement System			
		c. Primary and/or Family Benefits under the Social Security Act			

The above statements are true and complete to the best of my knowledge and belief and I hereby authorize any hospital or physician who has treated me or their person who has attended me or examined me, or any company or government agency to furnish the Division of State Group Insurance, or their representative, any and all information with respect to any illness, injury, medical history, consultations, prescriptions, treatments or benefits and copies of all applicable records. A photostatic copy of this form will be as valid as the original.

Employee's Signature _____ Date _____

EMPLOYER'S PART

Date of Hire	Effective date of Ins.	Last day worked	Reason for stopping work	Date returned to work	Occupation at time of Disability

- 1.) Is the employee entitled to benefits by virtue of employment? Yes No
- 2.) Employee's SSN: ____/____/____
- 3.) Bi-weekly Earnings at time of Disability: \$ _____
- 4.) Employee is eligible for accumulated accident/sick leave time as of date of disability for ____ weeks and ____ days, ending on _____.
- 5.) State Regular or Disability Retirement Benefit \$ _____ per week.
- 6.) Worker's Compensation Benefits \$ _____ per week.

Name & Address of Employer _____ Signed _____

_____ Title _____

_____ Date _____ Tel. No. _____

A person who knowingly and with intent to injure, defraud or deceive any insurance company who files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of the third degree.

ATTENDING PHYSICIAN'S STATEMENT

Name of Patient: _____ Date of Birth: ____ / ____ / ____ Employer: _____

HISTORY

- When did symptoms first appear or accident happen? ____ / ____ / ____
- Date patient ceased work because of disability? ____ / ____ / ____
- Has patient ever had same or similar condition? Yes No
If "Yes", state when and describe: _____
- Is condition due to injury or sickness arising from patient's employment?
 Yes No Unknown
- Names and addresses of other treating physicians:

DIAGNOSIS (Including any complications)

Date of last examination	Diagnosis (including any complications)	Subjective symptoms	Objective findings (including current x-rays, EKGs, laboratory data and any clinical findings)
____ / ____ / ____	_____ _____ _____	_____ _____ _____	_____ _____ _____

DATES OF TREATMENT

Date of first visit	Date of last visit	Frequency of visits
____ / ____ / ____	____ / ____ / ____	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (specify) _____

NATURE OF TREATMENT (Including surgery and medications prescribed, if any)

PROGRESS

- Has patient recovered? improved? unchanged? retrogressed?
- Is patient ambulatory? house confined?
- Has patient been hospital confined? Yes No (If yes, provide Name and Address of Hospital) _____
Confined from ____ / ____ / ____ through ____ / ____ / ____

CARDIAC (if applicable)

- Functional capacity
 Class 1 - No limitation Class 2 - Slight limitation Class 3 - Marked limitation Class 4 - Complete limitation
- Blood Pressure reading at last visit: _____
Systolic _____ Diastolic _____

PHYSICAL IMPAIRMENT (*as defined in Federal Dictionary of Occupational Titles)

- Class 1 - No limitation of functional capacity; capable of heavy work. No restrictions. (0 - 10%)
 - Class 2 - Medium manual activity. (15 - 30%)
 - Class 3 - Slight limitation of functional capacity; capable of light work. (35 - 55%)
 - Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity. (60 - 70%)
 - Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary) activity. (75 - 100%)
- Remarks: _____

MENTAL / NERVOUS IMPAIRMENT (if applicable)

- Define "stress" as it applies to this patient: _____
 - What stress and problem with interpersonal relations has patient had on job? _____
 Class 1 - Patient is able to function under stress and engage in interpersonal relations. No limitations.
 Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations. Slight limitations.
 Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations. Moderate limitations.
 Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations. Marked limitations.
 Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment. Severe limitations.
- Remarks: _____

PROGNOSIS

- Patient is now totally disabled?
Patient's job: Yes No
Any other work: Yes No
- What job duties is patient incapable of performing?

- Do you expect a fundamental or marked change in the future?
Patient's job: Yes No Any other work: Yes No
a.) If YES, when will patient recover sufficiently to perform duties?
Patient's job: 1 month 1-3 Mo. 3-6 Mo. Never ____ / ____ / ____
Other work: 1 month 1-3 Mo. 3-6 Mo. Never ____ / ____ / ____
b.) If NO, please explain: _____

REHABILITATION

	Patient's job	Any other work
1. Is patient a suitable candidate for further rehabilitation services? (i.e., cardiopulmonary program, speech therapy, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Can present job be modified to allow for handling with impairment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. When could trial employment commence? (FT=full-time, PT=part-time)	<input type="checkbox"/> FT <input type="checkbox"/> PT	<input type="checkbox"/> FT <input type="checkbox"/> PT
4. Would vocational counseling and/or retraining be recommended?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Attending Physician's Name: _____ Physician's Signature: _____
Address: _____ Date: ____ / ____ / ____ Phone: _____
Remarks: _____

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