J.P. FARLEY CORPORATION
WE HAVE A BETTER PLAN.

P.O. Box 458022 • Westlake, Ohio 44145
Toll Free: 800.634.0173 • **Fax:** 440.250.4301
benefits@jpfarley.com • **www.JPFarley.com**

DISABILITY INCOME CLAIM FORM

PART A: Must Be Completed by EMPLOYEE

Employer	Branch Location	Group Number
Employee's Last Name	First M.I.	Date of Birth (MM/DD/YYYY) ☐ Male ☐ Female
Home Address	Street ☐ Check here if new	Social Security Number (000-00-0000)
City	State Zip	If Name Change, Give Former Name
Home Phone ( ) -	Work Phone ( ) -	Email Address

What sickness or injury has caused your disability? (Please describe in your own words.)	When did your disability start? (MM/DD/YYYY)
Is your disability due to an accident? ☐ Yes ☐ No — If yes, where did the accident happen? What happened? Explain.	First full day not worked due to your disability. (MM/DD/YYYY)

Is your sickness or injury work related? ☐ Yes ☐ No	If yes, have you or will you file a claim for Worker's Compensation? ☐ Yes ☐ No	Are you filing a claim for Unemployment Compensation? ☐ Yes ☐ No

When did you first see a doctor for your condition? (MM/DD/YYYY)	Name and Address of Doctor
Did you go to the emergency room first? ☐ Yes ☐ No — If yes, when? (MM/DD/YYYY)	If yes, provide the name and address of hospital.
Have you been hospitalized for your condition? ☐ Yes ☐ No — If yes, give dates of confinement. (MM/DD/YYYY through MM/DD/YYYY)	If yes, provide the name and address of hospital.

AUTHORIZED TO RELEASE INFORMATION – I hereby authorize any insurance company, prepayment organization, employer, hospital or physician to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge.

Signature of Patient _____ Date _____

Please Note: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information as defined by GINA, include an individual's family medical history, the results of an individual's or family members' genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

PART B: Must Be Completed by EMPLOYER

Employer	Work Phone ( ) -	Email Address
Work Address Street	City	State Zip

Employee's Name & Occupation	Has Employment Terminated? ☐ Yes ☐ No If yes, when? For What Reason?

Effective Date of Coverage (MM/DD/YYYY)	Last Day Worked (MM/DD/YYYY)	Date Returned to Work (MM/DD/YYYY)	Is Disability Work-Related? ☐ Yes ☐ No

Benefit Amount $ / week	Weekly Salary $ / week	Maximum Weeks	What Percentage of Total Compensation Employer Pays? %

Signature of Employer Representative | Print Name of Employer Representative | Title | Date

CONTINUED NEXT PAGE.

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DISABILITY INCOME CLAIM FORM (Continued):

ATTENDING PHYSICIAN STATEMENT

PART C: MUST BE COMPLETED BY PHYSICIAN (please print)

Employee's Last Name	First	M.I.	Date of Birth (MM/DD/YYYY)

Please Note: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information as defined by GINA, include an individual's family medical history, the results of an individual's or family members' genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

HISTORY

When did the symptoms first appear or accident happen? Month _____ Day _____ Year _____

Date patient ceased work because of disability. Month _____ Day _____ Year _____

Has patient ever had same or similar condition? ☐ Yes ☐ No

If yes, when and describe:

Is condition employment related? ☐ Yes ☐ No

DIAGNOSIS (including and complications)

Diagnosis: (ICD-9 and Description)

Primary and secondary diagnosis codes: 1. _____ 2. _____

If condition is related to pregnancy, please indicate: LMP _____ EDC _____

Current Subjective Symptoms:

Objective findings: (x-rays, laboratory data, and other clinical findings)

Medical Necessity for Continued Disability: (Please provide reason employee is unable to return to work.)

TREATMENT

Date of first visit: Month _____ Day _____ Year _____ Date of most recent visit: Month _____ Day _____ Year _____

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify):

Nature of Treatment: (List all surgeries, procedures, diagnostic tests and results, consultations, etc.)

Medications: (If any)

PROGRESS / PROGNOSIS

Has the patient: ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

Is the patient: ☐ Ambulatory ☐ House Confined ☐ Bed Confined ☐ Hospital Confined From_____ Through_____

Name and address of hospital:

	Current Occupation	Any Other Occupation
Is patient now totally disabled?	☐ Yes ☐ No	☐ Yes ☐ No
If not totally disabled, when was patient able to return to work?	☐ Full-time ☐ Part-time	☐ Full-time ☐ Part-time
What duties of the patient's job is he/she incapable of performing?		

Estimate date of return to work: Month _____ Day _____ Year _____

Progress Notes can be sent via mail or Fax 440.250.4301 for your convenience.

CONTINUED NEXT PAGE

DISABILITY INCOME CLAIM FORM (Continued):

FUNCTIONAL CAPACITY

(Cardiac Scale based on American Heart Association Guidelines)

Blood pressure (last visit) _____/_____

- ☐ Class 1: No limitation.
- ☐ Class 2: Slight limitation.
- ☐ Class 3: Marked limitation.
- ☐ Class 4: Complete limitation.

Remarks:

PHYSICAL IMPAIRMENT

Please indicate degree of physical impairment as it relates to patient's ability to perform his/her job.

- ☐ Class 1: 0-10% No restriction or limitation of functional capacity; capable to work.
- ☐ Class 2: 15-30% Medium manual activity.
- ☐ Class 3: 35-55% Slight limitation of functional capacity; capable of light work.
- ☐ Class 4: 60-70% Moderate limitation of functional capacity; capable of sedentary activity.
- ☐ Class 5: 75-100% Severe limitation of functional capacity; incapable of minimal activity.

Remarks:

MENTAL/NERVOUS IMPAIRMENT

Please indicate definition of stress as it relates to patient; and patient's ability to function under stress and engage in interpersonal relations as it relates to his/her job.

- ☐ Class 1: No limitations; Patient is able to function under stress and engage in interpersonal relations.
- ☐ Class 2: Slight limitations; Patient is able to function in most stress situations and engage in most interpersonal relations.
- ☐ Class 3: Moderate limitations; Patient is able to engage in only limited stress situations/interpersonal relations.
- ☐ Class 4: Marked limitations; Patient is unable to engage in stress situations or engage in interpersonal relations.
- ☐ Class 5: Severe limitations; Patient has significant loss of psychological, physiological, personal and social adjustment.

Define "stress" as it applies to the patient.

What stress and problems in interpersonal relations has this patient had on his/her job?

Remarks:

EMPLOYMENT

Is patient still under your care for this condition? ☐ Yes ☐ No

Patient was totally and continuously disabled (unable to work): From _____ Through _____

Patient returned to work: Month _____ Day _____ Year _____

If still disabled, patient should be able to return to work: Month _____ Day _____ Year _____

ADDITIONAL REMARKS

Physician's Name	Specialty/Degree	Phone ( ) -
Home Address	Street	Fax ( ) -
City	State Zip	Email Address

Signature of Physician

Date

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▶ Send Claim: Completed form (all parts) and the required documentation to:

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