



Instructions: (1) Employee completes Part A (2) Physician completes Part B (3) Employer completes Part C.

PART A Employee information

Employee Name (First, Middle Initial, Last) _____ Male Birthdate _____ Social Security # _____
 Female _____

Home Address _____

Reason for Claim: Illness Accident _____ If 'accident' please provide date, place and how it happened below

Was illness or accident _____ Date _____ Place _____
Work-related? Yes No _____ How _____

How long were or will you be physically unable to work? _____

First date of disability _____ Last day of disability _____

AUTHORIZATION TO RELEASE INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, Insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, employer or third party administrator having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my dependents and any other non-medical information of me or my dependents to give my employer, third party administrator or its plan supervisor, MedCost Benefit Services, LLC, or its legal representative, any and all such information.

I UNDERSTAND information obtained with the Authorization will be used by MedCost Benefits Services, LLC, to determine eligibility for coverage and eligibility for benefits under an existing plan. Any information obtained will not be released by MedCost Benefit Services, LLC, to any person or organization except to the plan administrator, my employer, third party administrator, reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with the claim, or as may be otherwise lawfully required or as I may further authorize. **I KNOW** that I may request to receive a copy of this Authorization.

I AGREE that a photocopy of this Authorization shall be as valid as the original. **I AGREE** this Authorization shall be valid for two and one half years from the date shown below, or for the duration of this claim, if longer.

Date _____ Employee's signature _____

PART B Attending Physician's Statement

Nature of sickness/injury (Describe complications, if any) _____

Date and Nature of surgical or obstetrical procedure, if any _____

The patient has been continuously unable to work _____ If still disabled, provide the expected date to return to work _____
From (date): _____ Through (date): _____

Have you discharged the patient? Yes on (date) _____ First date of treatment during this disability period? _____
 No _____

If this claim is due to pregnancy, give estimated delivery date _____

Physician's Name _____ Please Print _____ Physician's signature _____

Address _____ Street _____ Date _____

City _____ State _____ Zip _____

PART C Employer's Statement

NOTE: YOUR CLAIM CANNOT BE PROCESSED UNTIL YOUR EMPLOYER COMPLETES THIS SECTION

Employee's Name _____ Status: Active Retired Lay-off Leave of Absence

Last day Employee worked _____ Has the Employee returned to work as of the date this claim was filed? No Yes, on (Date) _____

Provide weekly salary: \$ _____ Were injuries or sickness in any way connected with the Employee's occupation? No Yes

Signature of Employer's Representative: _____ Date: _____