StirlingBenefits™
Evolving the Business of Benefits℠

GROUP ACCIDENT OR SICKNESS INITIAL CLAIM FORM

INSTRUCTIONS: Employee must complete PART I. Take form to your Physician for completion of PART II. Return form to your Employer for completion of PART III. Completed form must be forwarded to the above address.

PART I – EMPLOYEE'S STATEMENT

1. I hereby apply for benefits due me on account of sickness or injury, which has caused me to be continuously unable to work since __________________, 20_______.
2. Print full name ______________________________ Sex _______ Date of Birth ______________ _______-_______-_______
   Mo. Day Yr. Social Security No.
3. Residence address___________________________________ City _________________ State ____________ Zip _________
4. Employed by ____ Located at _______________________________________
5. Does ailment result from your occupation? ☐ Yes ☐ No When did sickness/injury begin? ____________________
6. Cause of disability (Describe sickness or injury) ____
   ____
7. If hospitalized give date admitted __________________, 20_______ and date discharged ________________, 20_______
8. If due to accident, how did it occur? ____
   Where ____ When ______________________, 20________ ☐ AM or ☐ PM
9. Name of doctor first consulted __________________________________ Date of first visit __________________________
10. Date of return (or expected return) to work ____, 20______________

I hereby certify that the foregoing answers are true and correct to the best of my knowledge and belief and hereby authorize all doctors or other persons who treated me and all hospitals or other institutions to furnish full information (including full copies of their records) regarding this claim to Stirling Benefits, Inc. A photo static copy of this authorization shall be considered as effective and valid as the original.

Dated _____________________, 20_______ Signature of Employee ____

PART II – PHYSICIAN'S STATEMENT

1. Full name of patient ____
2. Nature and cause of disability ____ ICDA CODE ________________
   Due to pregnancy? ☐ Yes ☐ No If Yes, give date of last menstrual period ______________________, 20________
3. Did sickness or injury arise out of patient's employment? ☐ Yes ☐ No
4. Date first treated _______________, 20_______ Date symptoms first appeared or accident happened ______________, 20______
5. Has patient been disabled solely by this injury or sickness as to be unable to work? ☐ Yes ☐ No
   If so, for how long? From __________________, 20_________ Through ____________________, 20________, Inclusive

6. If still disabled, when do you expect the employee will be able to return to work? ____________________

7. Date of ALL visits: At my office ____________________ At patient's home ____________________
   At ____________________ Hospital ____________________

8. If patient was hospitalized give dates. From __________, 20______ To __________, 20______
   Name and date of any operation performed ____________________ on __________, 20______

9. Is patient still under your care for this condition? ☐ Yes ☐ No If no, provide discharge date __________, 20_____

Dated __________, 20_____ ____________________ ____________________ __________
Physician's Name (Printed) Signature Degree

____________________ ____________________ (_____)__________
Street Address City, State and Zip Area Code and Phone No.

PART III – EMPLOYER'S STATEMENT Policy No. ____-______ Scheduled Benefit __________

1. Name of Employee ____________________ Soc. Sec. No. ______-_____-______ Date Employed __________

2. Was claimant employed and eligible for insurance when disability began? ☐ Yes ☐ No Occupation __________

3. Did injury or illness arise out of occupation? ☐ Yes ☐ No If Yes, is this disability being reported to the state or any insurance company as a Worker's Compensation Claim? ☐ Yes ☐ No List amount of weekly compensation payment $ __________

4. Wages: If salaried employee, show applicable rate $ __________ Monthly or $ __________ Weekly
   If hourly employee, show hourly rate $ __________ and number of hours worked weekly __________

5. Date last worked **before** total disability began __________, 20______
   Date became unable to work __________, 20______

6. Date returned to work __________, 20______ **or** Date of expected return __________, 20______

Name of Employer ____________________

Address ____________________ City ____________________ State __________ Zip ______

Date __________, 20______ Signed by ____________________

Title ____________________ Phone No. ____________________

PART IV – ADMINISTRATOR'S RECORD

1. Waiting Period ____________________

2. Disability Dates ____________________

3. Gross __________ FICA __________ Net __________

<u>Mail completed form to:</u>
Stirling Benefits, Inc.
20 Armory Lane
Milford, CT 06460-3347