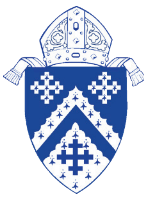

DIOCESAN GROUP LIFE AND PENSION OFFICE
WEEKLY DISABILITY BENEFITS CLAIM FORM

1404 EAST NINTH STREET, EIGHTH FLOOR • CLEVELAND, OH 44114-1722
216-696-6525 EXT. 5040 • FAX 216-621-9622 • hbo@dioceseofcleveland.org

PLEASE RETURN TO THE DIOCESE BENEFITS OFFICE UPON COMPLETION

TO BE COMPLETED BY EMPLOYER

EMPLOYEE NAME ____________________ LAST 4 DIGITS OF SS# __________

TITLE ____________________

CURRENT ANNUAL EARNINGS DIVIDED BY 52 = $ __________ EFFECTIVE DATE of LAST WAGE CHANGE __________

DATE LAST WORKED __________ DATE RETURNED TO WORKED __________

INJURED ON JOB? YES, EXPLANATION: ____________________

____

THE DATE THROUGH WHICH SICK PAY WILL BE PAID BY EMPLOYER: ____________________

(If this is blank, it will be assumed that no employer paid sick pay is involved in this claim)

NAME OF EMPLOYER (Church or Institution) ____________________

ADDRESS ____________________

DATE __________ AUTHORIZED SIGNATURE ____________________

TO BE COMPLETED BY EMPLOYEE

NAME ____________________

ADDRESS ____________________

TELEPHONE __________ DATE OF BIRTH __________ MALE ______ FEMALE ______

BEGINNING OF DISABILITY __________

IF DISABILITY DUE TO ACCIDENT, HOW, WHEN, WHERE DID IT OCCUR ____________________

____

DO YOU EXPECT PAYMENT FROM OTHER SOURCES BECAUSE OF THIS ACCIDENT (Insurance, Legal Action, etc.)? YES NO

I certify that these statements are complete and accurate and I hereby authorize any physician or other person, any hospital or other institution who has rendered care to me to release any and all information as may be required by The DIOCESAN GROUP LIFE & PENSION OFFICE or its representative. A photostat of this authorization shall be as valid as the original.

I understand that F.I.C.A Tax will be withheld from benefits and that disability benefits are subject to Federal Income Tax.

DATE __________ SIGNATURE ____________________

ATTENDING PHYSICIAN'S STATEMENT

DIAGNOSIS ____________________

____

HOSPITALIZED? YES NO IF YES: FROM __________ TO __________

PREGNANCY? YES NO IF YES: DUE DATE __________

DATE PATIENT FIRST CONSULTED YOU FOR THE DISABILITY CONDITION (Omit for Pregnancy) __________

PATIENT DISABLED AND UNABLE TO WORK? FROM __________ TO __________

DATE PATIENT HAS OR SHOULD BE ABLE TO RETURN TO WORK __________

PHYSICIAN'S NAME (PRINT) ____________________

PHYSICIAN'S (SIGNATURE) ____________________ DATE __________

TELEPHONE __________ ADDRESS ____________________