DIOCESAN GROUP LIFE AND PENSION OFFICE
WEEKLY DISABILITY BENEFITS CLAIM FORM

1404 East Ninth Street Eighth Floor
Cleveland, Ohio 44114-1722

TO BE COMPLETED BY EMPLOYER

1. EMPLOYEE NAME:		2. SOCIAL SECURITY #
3. OCCUPATION	4. CURRENT ANNUAL EARNINGS DIVIDED BY 52 = $	4A. EFFECTIVE DATE OF LAST WAGE CHANGE
5. DATE LAST WORKED	6. DATE RETURNED TO WORK	7. INJURED ON JOB? IF YES, SEND EXPLANATION

8. THE DATE THROUGH WHICH SICK PAY WILL BE PAID BY THE EMPLOYER: (IF #8 IS BLANK, IT WILL BE ASSUMED THAT NO EMPLOYER PAID SICK PAY IS INVOLVED IN THIS CLAIM)

9. NAME OF EMPLOYER (church or institution)	ADDRESS
DATE	AUTHORIZED SIGNATURE

TO BE COMPLETED BY EMPLOYEE

1. NAME	ADDRESS:	CITY, ZIP	TELEPHONE #
2. DATE OF BIRTH	3. BEGINNING OF DISABILITY	4. MALE_____ FEMALE_____	

5. IF DISABILITY DUE TO ACCIDENT - HOW, WHEN AND WHERE DID IT OCCUR: (use reverse side if necessary)

5A. DO YOU EXPECT PAYMENT FROM OTHER SOURCES BECAUSE OF THIS ACCIDENT (insurance, legal action, etc.)? YES ☐ NO ☐

6. I DO NOT WANT FEDERAL INCOME TAX WITHHELD FROM MY CLAIM CHECK ☐

FORM W-4S ATTACHED—PLEASE WITHHOLD FEDERAL INCOME TAX ☐ (WHOLE DOLLARS ONLY—MINIMUM IS $20 PER WEEK)

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.

Dated _____ 19____ Signed _____
(Signature of Employee)

ATTENDING PHYSICIAN'S STATEMENT

1. DIAGNOSIS	1A. HOSPITALIZED? ☐ YES ☐ NO IF YES: FROM _____ (date) TO _____ (date)
2. PREGNANCY? ☐ YES ☐ NO IF YES, EXPECTED DELIVERY DATE	REMARKS (use reverse side if necessary)

3. DATE PATIENT FIRST CONSULTED YOU FOR THE DISABILITY CONDITION (OMIT FOR PREGNANCY)

4. PATIENT DISABLED AND UNABLE TO WORK FROM THRU	5. DATE PATIENT HAS OR SHOULD BE ABLE TO RETURN TO WORK

PHYSICIAN'S NAME (Print)	SIGNATURE	DEGREE	TELEPHONE #
DATE	ADDRESS	CITY	STATE ZIP