EBSO
Expert Benefit Solutions

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PROOF OF SHORT TERM DISABILITY

Weekly Disability Income

EMPLOYEE'S STATEMENT – ALL QUESTIONS MUST BE ANSWERED. PLEASE RETURN COMPLETED FORM TO EMPLOYER.

Name of Employee	Member ID #	Date of Birth	☐ M ☐ F

Address Street City State Zip	Telephone Number
	( )

Date Total Disability Commenced	Date Total Disability Ceased	Is Claim Due To An Accident ☐ Yes ☐ No	Date Of Accident

Where Did Accident Occur	Describe Accident (Continue On Reverse If More Space Required)

Is This Claim The Result Of A Work Related Illness Or Injury? ☐ Yes ☐ No	Is this claim a result of a motor vehicle accident? ☐ Yes ☐ No

Was Another Person or Parties Responsible For Your Injury: ☐ Yes ☐ No	If Yes, please provide the name and address of the person or firm responsible and insurance company, if applicable.

AUTHORIZATION TO OBTAIN INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, clinic other medical related facility, insurance or reinsuring company, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children, not including any genetic information, to give EBSO or its legal representative, any and all such information. I UNDERSTAND the information obtained by use of the authorization will be used by EBSO for claim purposes. Any information obtained will not be released by EBSO to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required, or as I may further authorize.
I KNOW that I have a right to receive a copy of this authorization.
I AGREE that a photocopy of this authorization will be as valid as the original
I AGREE that this authorization will be valid for two years from the date shown below.

Signature of Employee **X**	Date

ATTENDING PHYSICIAN'S STATEMENT

In accordance with the Genetic Information Nondiscrimination Act of 2008 (GINA), please do not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services.

Diagnosis And Concurrent Conditions

Is Condition Due To Injury Or Sickness Arising Out Of Patient's Employment? ☐ Yes ☐ No	Pregnancy? ☐ Yes ☐ No	If Yes, Date Of LMP	Estimated Date Of Delivery

Date Of Service (If Previous Forms Submitted To This Carrier, You Need Show Only Dates Since Last Report)

Date Symptoms First Appeared Or Accident Occurred	Date Patient First Consulted You For This Condition	Patient Was Continuously Totally Disabled (Unable To Work) From Thru

If Still Disabled, **Please Estimate** Date Patient Should Be Able To Return To Work

Physician's Name (Please Print)	Physician's Signature Degree	Date

Address Street City State Zip	Telephone Number ( )

EMPLOYER'S STATEMENT

Employee Name	Date Employed	Eligibility Date	Insurance Effective Date

Is This A Recurrence Within 2 Weeks Of Previous Disability? ☐ Yes ☐ No	Occupation	Weekly Wage $	Weekly Benefit $

Date Last Worked	Date Disability Commenced	Date Disability Ceased	Has Employee Returned To Work If Yes, Date? ☐ Yes ☐ No

Do You Have Information Re Workers' Compensation Or Other Disability Income Benefits That Would Affect This Claim: If Yes, Please Explain On Reverse Side ☐ Yes ☐ No	Do You Have Any Information Which Would Assist In Determining The Merits Of This Case? If Yes, Please Explain On Reverse Side ☐ Yes ☐ No

Employer	Address Street City State Zip

Signature Of Employer's Representative	Title	Date	Telephone Number ( )

Please send completed and signed copy to customerservice@ebsobenefits.com or to the fax number or mailing address at the top of this form. Questions, contact EBSO Customer Service at 651-695-2500 or 800-486-7664.