Group Disability Insurance Claim Form

Employer Information

Employer Name

Policy Number

Employer Address

Contact Person

Contact Email

Contact Phone

Employee Information

Employee Name

Employee ID

Date of Birth

Address

Phone

Email

Disability Details

Date Last Worked

Date Disability Began

Nature of Disability

Description of Disability

Has employee returned to work?

If yes, date returned

Physician/Medical Information

Physician Name

Phone

Address

Authorization & Signature

Authorization Statement

Employee Signature

Date