Short-Term Disability Claim Statement

Employee Information

Full Name

Employee ID

Date of Birth

Phone Number

Address

Employment Information

Employer Name

Department

Job Title

Employment Status

Disability Details

Date Disability Began

Nature of Disability / Illness

Treating Physician's Name

Physician Contact Number

Treatment Details

Estimated Return to Work Date

Authorization & Acknowledgment

I certify that the information provided is true and complete to the best of my knowledge. I authorize the release of medical and employment information as necessary to process my claim.

Signature

Date