bac

SHORT-TERM DISABILITY CLAIM FORM

PLEASE COMPLETE THIS FORM AS SOON AS IT APPEARS THAT YOU WILL QUALIFY FOR DISABILITY BENEFITS AND SUBMIT TO: **BAC – ATTN: CLAIMS DEPT., PO BOX 107, REYNOLDSBURG, OH 43068-0107**, FAX TO **614.863.0184**, OR EMAIL TO **BACDISABILITY@BACTPA.COM**

A. STATEMENT OF EMPLOYEE: (TO BE FILLED OUT BY EMPLOYEE – PLEASE ANSWER ALL QUESTIONS FULLY)

1. YOUR NAME (LAST, FIRST, M.): | DATE OF BIRTH (MM/DD/YYYY): | ID NUMBER:

2. HOME ADDRESS: | CITY: | STATE: | ZIP CODE:

3. TELEPHONE NUMBER: | EMAIL ADDRESS: | SEX: ◯ **MALE** ◯ **FEMALE** | IS THIS A NEW ADDRESS?: ◯ **NO** ◯ **YES**

4. PLAN SPONSOR/EMPLOYER NAME:

5. YOUR OCCUPATION: | DID DISABILITY RESULT FROM EMPLOYMENT? ◯ **YES** ◯ **NO**

6. HAVE YOU BEEN CONTINUOUSLY DISABLED SINCE YOU BECAME UNABLE TO WORK?:
◯ **YES, APPROXIMATELY WHEN DO YOU FEEL YOU WILL BE ABLE TO RESUME WORK?**
◯ **NO, WHEN DID YOU AGAIN BECOME ABLE TO WORK?** **DATE:** **HOUR:** ◯ **A.M.** ◯ **P.M.**

7. REASON FOR DISABILITY:
◯ **ACCIDENT – DESCRIBE INCLUDING DATE AND PLACE:**
◯ **SICKNESS – WHEN DID SYMPTOMS FIRST APPEAR?**

8. HAVE YOU BEEN HOSPITAL CONFINED?: ◯ **NO** ◯ **YES, FROM WHEN:** **TO:** | NAME OF HOSPITAL:
HOSPITAL ADDRESS: | CITY: | STATE: | ZIP CODE:

9. DO YOU HAVE DISABILITY INSURANCE WITH OTHER COMPANIES?
◯ **NO** ◯ **YES, PROVIDE COMPANY NAMES & POLICY NUMBERS:**

10. NAME(S) OF PHYSICIAN(S) TREATING THIS... | SICKNESS/ACCIDENT/INJURY? | DATE CONSULTED:

11. **THESE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.** The member's signature provides consent to release information concerning health care advice, treatment or supplies provided to the patient. This information will be used to evaluate, analyze, manage and/or administer claims for benefits. BAC may provide the employer named above with any benefit calculation used in payment of this claim. This authorization is valid for the term of the policy under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is valid as the original. I understand that BAC may further disclose this information if required under law. This consent is subject to revocation at any time.

X _____ _____
EMPLOYEE'S SIGNATURE: **DATE SIGNED** (MM/DD/YYYY):

B. EMPLOYER INFORMATION: (TO BE COMPLETED BY EMPLOYER)

TO BE COMPLETED BY EMPLOYER

EFF. DATE OF INSURANCE: | EMPLOYEE'S START DATE: | DATE LAST WORKED:

WAS CLAIMANT IN YOUR EMPLOY WHEN DISABILITY BEGAN?
◯ **YES** ◯ **NO**

WAS INSURANCE IN FORCE WHEN DISABILITY BEGAN?
◯ **YES** ◯ **NO**

IS EMPLOYEE'S INSURANCE STILL IN FORCE?
◯ **YES** ◯ **NO, GIVE DATE OF TERMINATION:**

EMPLOYEE'S SALARY:
◯ **WEEKLY, $:** ◯ **MONTHLY, $:**

HAS EMPLOYEE RETURNED TO WORK?
◯ **NO** ◯ **YES, GIVE DATE OF RETURN:**

GROUP POLICY HOLDER: | TELEPHONE NUMBER:

GROUP POLICY HOLDER'S SIGNATURE: | TITLE: | DATE SIGNED (MM/DD/YYYY):

X

PLEASE, HAVE YOUR PHYSICIAN COMPLETE ALL INFORMATION ON THE NEXT TWO PAGES

C. ATTENDING PHYSICIAN'S STATEMENT: (THIS SECTION TO BE COMPLETED BY PHYSICIAN – PLEASE PRINT)

TO BE COMPLETED BY PHYSICIAN

HISTORY:

WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN?

DATE PATIENT CEASED WORK BECAUSE OF DISABILITY?

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?

◯ **NO** ◯ **YES, STATE WHEN AND DESCRIBE:**

NAMES OF ANY ADDITIONAL TREATING PHYSICIANS:

ADDRESS OF ADDITIONAL PHYSICIANS:

IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT?

◯ **YES** ◯ **NO** ◯ **UNKNOWN**

DIAGNOSIS:

DIAGNOSIS (INCLUDING ANY COMPLICATIONS):

DATE OF LAST EXAMINATION:

SUBJECTIVE SYMPTOMS:

IS DISABILITY DUE TO PREGNANCY?

◯ **NO** ◯ **YES**

EXPECTED DELIVERY DATE:

C-SECTION SCHEDULED DATE:

OBJECTIVE FINDINGS (INCLUDING CURRENT X-RAYS, EKG'S, LABORATORY DATA AND ANY CLINICAL FINDINGS):

DATES AND NATURE OF TREATMENT:

DATE OF FIRST TREATMENT:

DATE OF LAST TREATMENT:

FREQUENCY:

◯ **WEEKLY** ◯ **MONTHLY** ◯ **OTHER:**

NATURE OF TREATMENT (INCLUDING SURGERY AND MEDICATIONS PRESCRIBED, IF ANY):

PROGRESS:

HAS PATIENT...

◯ **RECOVERED?** ◯ **IMPROVED?** ◯ **UNCHANGED?** ◯ **RETROGRESSED?**

PHYSICAL IMPAIRMENTS:

◯ **CLASS 1 – NO LIMITATION OF FUNCTIONAL CAPACITY; CAPABLE OF HEAVY WORK. NO RESTRICTIONS**
◯ **CLASS 2 – MEDIUM MANUAL ACTIVITY**
◯ **CLASS 3 – SLIGHT LIMITATION OF FUNCTIONAL CAPACITY: CAPABLE OF LIGHT WORK**
◯ **CLASS 4 – MODERATE LIMITATION OF FUNCTIONAL CAPACITY; CAPABLE OF CLERICAL/ADMINISTRATIVE (SEDENTARY) ACTIVITY**
◯ **CLASS 5 – SEVERE LIMITATION OF FUNCTIONAL CAPACITY; INCAPABLE OF MINIMUM (SEDENTARY) ACTIVITY**

IS PATIENT...

◯ **AMBULATORY?** ◯ **HOUSE CONFINED?** ◯ **BED CONFINED?** ◯ **HOSPITAL CONFINED – IF YES, ANSWER THE NEXT THREE...**

NAME OF HOSPITAL PATIENT HAS BEEN CONFINED AT:

CONFINED FROM:

CONFINED THROUGH:

HOSPITAL'S MAILING ADDRESS:

CITY:

STATE:

ZIP CODE:

PHYSICIAN'S STATEMENT CONTINUES ON THE NEXT PAGE

C. ATTENDING PHYSICIAN'S STATEMENT: (THIS SECTION TO BE COMPLETED BY PHYSICIAN – PLEASE PRINT)

TO BE COMPLETED BY PHYSICIAN

PROGNOSIS:

	PATIENT'S JOB:		ANY OTHER WORK:	
IS PATIENT NOW TOTALLY DISABLED?	◯ YES	◯ NO	◯ YES	◯ NO
WHAT DUTIES OF PATIENT'S JOB IS HE/SHE INCAPABLE OF PERFORMING:				
DO YOU EXPECT A FUNDAMENTAL MARKED CHANGE IN THE FUTURE?	◯ YES	◯ NO	◯ YES	◯ NO
IF YES, WHEN WILL/OR DID PATIENT RECOVER SUFFICIENTLY TO PERFORM DUTIES?	◯ ___ / ___ / 20___		◯ ___ / ___ / 20___	
IF NO, PLEASE EXPLAIN:				
OTHER REMARKS?:				

PHYSICIAN'S INFORMATION:

PHYSICIAN'S NAME:	SPECIALTY:	TELEPHONE NUMBER:

PHYSICIAN'S MAILING ADDRESS:	CITY:	STATE:	ZIP CODE:

TO ALL PHYSICIANS, PRACTITIONERS, HOSPITALS, VOCATIONAL REHABILITATION COUNSELORS, AND WORKER'S COMPENSATION INSURANCE CARRIERS ("PROVIDER"):

X _____ _____

PHYSICIAN/PROVIDERS'S SIGNATURE: **DEGREE/TITLE:** **DATE SIGNED** (MM/DD/YYYY):

FOLD HERE FOR USE WITH A NO. 10 WINDOW ENVELOPE

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FEEL FREE TO CONTACT US WITH ANY QUESTIONS OR COMMENTS:

ON THE WEB: **https://www.bactpa.com**
TOLL FREE: **1.800.521.2654**
FACSIMILE: **1.614.863.0184**
EMAIL: **bacdisability@bactpa.com**

BUSINESS ADMINISTRATORS & CONSULTANTS, INC.
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