FCE BENEFITS

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For FCE use only
Claim No.

DISABILITY CLAIM FORM

1. Employee's Name (First, Middle Initial, Last) Nombre del Empleado (Primer, Segunda Inicial, Apellido)	2. Employee's Date of Birth Fecha de Nacimiento del Empleado	3. Employer's Name Nombre del Patrón
4. Employee's Address / Domicilio del Empleado	5. Home Phone Telefono del Case	6. Social Security Number Numero de Seguro Social

To all physicians and other medical professionals, hospitals and other medical-care institutions, and to insurers, medical or hospital service and prepaid health plans, employers and group policy holders, contract holders or benefit plan administrators: You are authorized to provide FCE and any benefit plan administrators, consumer reporting agencies, attorneys and independent claim administrators acting on FCE's behalf, with information concerning medical care, advice, treatment or supplies provided the patient, including information related to mental illness and drug abuse or alcoholism, and any employment related information regarding the patient. This information will be used for the purpose of evaluating and administering claims for benefits. I understand that I have a right to receive a copy of this authorization upon request. I agree that a photocopy of this authorization is as valid as the original.

Para todos los médicos y otros profesionales médicos, hospitales y otras instituciones de atención médica, y para las aseguradoras, servicio médico u hospital y planes de salud prepagados, los empleadores y los asegurados de grupo, los titulares de contratos o administradores de planes de beneficios: Usted está autorizado para proporcionar FCE y cualquier beneficiar a los administradores del plan, las agencias de informes de los consumidores, abogados y administradores de reclamaciones independientes que actúan en nombre del FCE, con información relativa a la atención médica, consejo, tratamiento o suministros proporcionados al paciente, incluyendo la información relacionada con las enfermedades mentales y el abuso de drogas o alcoholismo, y cualquier información relacionada con el empleo en relación con el paciente. Esta información será utilizada con el propósito de evaluar y administrar las solicitudes de prestaciones. Yo entiendo que tengo el derecho de recibir una copia de esta autorización cuando la solicite. Estoy de acuerdo que una fotocopia de esta autorización es tan válida como el original.

7. Employee Signature
Firma del Empleado _____ Date / Fecha _____

EMPLOYER'S STATEMENT / DECLARACION DEL PATRON

Employee's Name	Plan Number	Is the sickness/injury related to any employment? Yes____No ____

Job Title and Duties	Date Employed: _____ Hours Worked Weekly: _____ Salary or Rate of Pay: _____ Date Employee Last Worked: _____

When did employee become totally disabled? Date	When did employee return to light work? Date	When did employee return to full-time work? Date	If not returned, when expected to return? Date
Is he/she still employed? Yes____No ____	Was he/she laid off? Yes____No ____ Date	Was leave of absence granted? Yes____No ____ Date	Was employment terminated? Yes____No ____ Date

To the best of my knowledge and belief, all of the answers given by the employee and by me are true and complete. I recommend payment. Yes____No ____	Employer's Name and Mailing Address

Signed on behalf of employer by: _____	Date	Title

PHYSICIAN OR SUPPLIER INFORMATION—INFORMACION DEL MEDICO O PROVEEDOR

Date	Illness (first symptom) or injury (accident) or pregnancy (LMP)	Date first consulted you for this condition	Has patient had same or similar symptoms? Yes____No ____

Name of referring physician	For services related to hospitalization give hospitalization dates. Admitted Discharged

Name & address of facility where services rendered (if other than home or office)	Date Unable to Work Due to Disability: _____ Estimated Return to Work: _____ Expected Delivery Date (for pregnancy): _____

Diagnosis or nature of illness or injury.
1.
2.
3.
4.

Signature of Physician or Provider

Physician's or Supplier's Name, Address, Zip Code & Telephone No.

ALL QUESTIONS MUST BE FULLY ANSWERED OR MAY RESULT IN DELAYED PROCESSING.
TODAS LAS PREGUNTAS DEBEN SER CONTESTADAS COMPLETAMENTE O SE PRODUCIRA UN RETRASO.