

JFP Benefit Management, Inc.

Disability Claim Form

Complete & Return to:
JFP Benefit Management, Inc.
 P.O. Box 189, Jackson, MI 49204
 (517) 784-0535 Phone – (517) 784-0821 Fax
 cservice@jfpbenefitmanagement.com

Employer – Complete This Section

Last Day Worked	Hours Worked	Rate \$			
		<input type="checkbox"/> Yr	<input type="checkbox"/> Mo	<input type="checkbox"/> Wk	<input type="checkbox"/> Hr
Employer	Occupation	<input type="checkbox"/> Hourly <input type="checkbox"/> Salary			
Reason Employee Stopped Work:	<input type="checkbox"/> Disability <input type="checkbox"/> Retired	<input type="checkbox"/> Personal Leave <input type="checkbox"/> Vacation	<input type="checkbox"/> Temporary Layoff <input type="checkbox"/> Probationary Layoff <input type="checkbox"/> Permanent Layoff		
<input type="checkbox"/> Other (Explain) _____					
<input type="checkbox"/> Non-Occupational Disability			<input type="checkbox"/> Occupational Disability		
Authorized Signature			Date Completed		
Date Returned To Work 10/03/13			Hours Worked		

Employee – Complete This Section

Name – Last	First	Middle Initial	Social Security #		
Address – Street	City	State	Zip	Telephone Number	
Age	Employer	<input type="checkbox"/> Hourly		<input type="checkbox"/> Salaried	
Occupation					
Your Doctor's Name				Telephone Number	
Address – Street		City	State	Zip	
Nature Of Your Disability					
Date Your Disability Began			Is Your Disability Work Related <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Your Disability Is The Result Of An Accident or injury, please Fill In Below					
Date Of Accident or injury	Date Of Accident or injury	Date Of Accident or injury	Date Of Accident or injury		
How Did Accident or injury Happen?					
Did You Stop Working Because Of This Accident or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did You Stop Working Because Of This Accident or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did You Stop Working Because Of This Accident or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Important

You Must Complete, Sign And Return This Form To Jfp Benefit Management, Inc. Before Any Benefit Can Be Released To You. Give The Form To Your Doctor To Have Statement On Back Filled Out.

I Hereby Authorize Any Insurance Company, Prepayment Organization, Hospital Or Physicians To Release All Information With Respect To Myself Or My Dependents Which May Have A Bearing On The Benefits Payable Under This, Or Any Other Plan Providing Benefits Or Services.

Employee's Signature	Date
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Disability Claim Form		Disability Claim Physician's Statement	
		Physician's Name	
Complete & Return To JFP Benefit Management, Inc. P.O. Box 189, Jackson, Mi 49204 (517) 784-0535 – Phone (517) 784-0821 – Fax cservice@jfpbenefitmanagement.com		Address	
		Telephone Number	Federal Tax I.D. #
		Physician – Complete This Section	
Patient's Name – Last	First	Initial	
Diagnosis Or Nature Of Above Patient's Sickness Or Injury (Describe Complications, If Any)			
Date Of First Treatment	Date Of Most Recent Treatment	Frequency Of Treatments	
Type Of Treatments			
Type(S) Of Medication Being Given			
Is Disability Caused By Or Related To Pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Give Estimated Date Of Delivery	
Date Of First Treatment After Last Day Worked	Is Patient Under Your Care Now <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, Date Of Release	
Did Disability Require Hospitalization <input type="checkbox"/> Yes <input type="checkbox"/> No	Did This Sickness Or Injury Arise From Patient's Employment <input type="checkbox"/> Yes ** <input type="checkbox"/> No		
** If Yes, Explain			
If Hospitalized, Dates Of In-Patient Confinement			
Admitted		Discharged	
Describe Any Surgical Or Obstetrical Procedure			
		Date Performed	
This Patient Has Been Continuously Disabled (Unable To Perform All Duties Of His Occupation)		From	Through
If Still Disabled, Estimated Date Patient Should Be Able To Return To Work			
Is Patient Mentally Competent To Conduct His Own Financial Affairs (I.E., The Endorsing Of Weekly Indemnity Checks?)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physician's Signature		Date	
Supplemental Physician's Report			
Date Of Most Recent Treatment		Revised/Estimated Return To Work Date	
If Condition Has Not Changed From Time Of Original Filing, Please Describe Briefly			
Physician's Signature		Date	