Short-Term Disability Insurance Claim Form

Personal Information

Full Name:

Date of Birth:

Address:

Phone Number:

Email:

Employment Information

Employer Name:

Job Title:

Start Date of Employment:

Disability Information

Disability Start Date:

Reason for Disability:

Treating Physician Name:

Physician Contact Number:

Certification and Authorization

I hereby certify that the above information is true and complete to the best of my knowledge. I authorize my physician to release medical information required to process this claim.

Signature:

Date:

Submit Claim