Employee Short-Term Disability Claim Form

Employee Information

Full Name: [   ]

Employee ID: [   ]

Department: [   ]

Email Address: [   ]

Disability Information

Start Date of Disability: [   ]

Expected Return Date: [   ]

Reason for Disability:

[   ]

Physician's Name: [   ]

Physician's Phone: [   ]

Authorization

☐ I authorize the release of my medical information for the purpose of disability benefits processing.

Employee Signature: [   ]

Date: [   ]

[Submit Claim]