Short-Term Disability Claim Form

Employee Information

Full Name:

Social Security Number:

Date of Birth:

Address:

Phone Number:

Email:

Employment Information

Employer Name:

Job Title:

Date Hired:

Disability Information

Last Day Worked:

Date Disability Began:

Nature of Disability:

Physician's Name:

Physician's Phone Number:

Certification and Signature

Signature:

Date:

Submit Claim