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
MWarren@jfpbenefitmanagement.com

Employer – Complete This Section

Last Day Worked	**Hours Worked**	**Rate** **$** ☐ Yr ☐ Mo ☐ Wk ☐ Hr
Employer	**Occupation**	☐ Hourly ☐ Salary

Reason Employee Stopped Work: ☐ Disability ☐ Retired ☐ Personal Leave ☐ Vacation ☐ Temporary Layoff ☐ Probationary Layoff ☐ Permanent Layoff

☐ Other (Explain) _____

☐ Non-Occupational Disability	☐ 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**		☐ Hourly	☐ 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** ☐ Yes ☐ 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? ☐ Yes ☐ Yes	**Did You Stop Working Because Of This Accident or injury?**	**Did You Stop Working Because Of This Accident or injury?** ☐ Yes	☐ Yes

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**

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	If Yes, Give Estimated Date Of Delivery
☐ Yes ☐ No	

Date Of First Treatment After Last Day Worked	Is Patient Under Your Care Now	If No, Date Of Release
	☐ Yes ☐ No	

Did Disability Require Hospitalization	Did This Sickness Or Injury Arise From Patient's Employment
☐ Yes ☐ No	☐ Yes ** ☐ No

**** If Yes, Explain**

If Hospitalized, Dates Of In-Patient Confinement

Admitted		Discharged	

Describe Any Surgical Or Obstetrical Procedure

	Date Performed

	From	Through
This Patient Has Been Continuously Disabled (Unable To Perform All Duties Of His Occupation		
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?)*	☐ Yes	☐ 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