DISABILITY CLAIM FORM

PO Box 19108
Raleigh NC 27619
(919) 877-9933

STATEMENT OF EMPLOYER

EMPLOYEE NAME	SOCIAL SECURITY NUMBER	EFFECTIVE DATE

OCCUPATION	FIRST DATE UNABLE TO WORK:	SALARY	IN YOUR OPINION, ARE EMPLOYEE ACTIVITIES CONSISTENT WITH TOTAL DISABILITY? ☐YES☐NO EXPLAIN:

DID DISABILITY ARISE OUT OF PATIENT'S EMPLOYMENT? ☐YES ☐NO IF YES, EXPLAIN:	IF EMPLOYEE HAS NOT RETURNED TO WORK, GIVE DATE EXPECTED TO RETURN:

EMPLOYER NAME:	AUTHORIZED REPRESENTATIVE'S SIGNATURE	DATE

STATEMENT OF PHYSICIAN

PATIENT'S NAME	DIAGNOSIS
DATE PATIENT FIRST CONSULTED FOR THIS CONDITION:	WHEN WAS PATIENT LAST EXAMINED BY YOU?
SUBJECTIVE SYMPTOMS	PROGRESS AND PRESENT STATUS
IS THE PATIENT INCAPABLE OF PERFORMING ALL PARTS OF HIS USUAL WORK? ☐YES☐NO	IF NOT, IS THE PATIENT ABLE TO PERFORM ANY OTHER WORK? ☐YES ☐NO
WAS HOUSE CONFINEMENT NECESSARY?	IF HOSPITALIZATION WAS INVOLVED, PLEASE GIVE DATES:

IF STILL DISABLED, WHEN IN YOUR OPINION WILL HE/SHE BE ABLE TO RETURN TO WORK?

DATE OF PROBABLE RETURN:____________________________

- ☐WITHIN 2 WEEKS
- ☐WITHIN 2 WEEKS TO 1 MONTH
- ☐WITHIN 1 MONTH TO 2 MONTHS
- ☐WITHIN 2 MONTHS TO 3 MONTHS
- ☐OVER 3 MONTHS
- ☐ NEVER

IF NOT STILL DISABLED, PLEASE GIVE DATE EMPLOYEE WAS RELEASE TO RETURN TO WORK

DATE	ATTENDING PHYSICIAN'S SIGNATURE	TAX ID #

STREET ADDRESS	CITY OR TOWN	STATE	ZIP CODE	TELEPHONE NUMBER