SOUTHERN NATIONAL
LIFE INSURANCE COMPANY, INC.
A subsidiary of Blue Cross and Blue Shield of Louisiana,
independent licensees of the Blue Cross and Blue Shield Association.

Short Term Disability Claim Form

P.O. Box 98044 ~ Baton Rouge, LA 70898-9044 ~ 225-295-2525 (ph) ~ 225-297-2665 (fax)

TO BE COMPLETED BY EMPLOYER

Company Name _____ Group Number _____

Address (Mailing) _____ Telephone Number _____

_____ Fax Number _____

Premium Contribution: Employee % _____ If premium paid by employee, is premium paid PRE-TAX?

Employer % _____ ❑ Yes ❑ No

Employee Information

Employee Name _____ Date of Hire ___/___/___ Basic Weekly Earnings $ _____

Contract Number _____ Social Security Number _____ Sex: ❑ M ❑ F

Effective Date of Coverage ___/___/___ Weekly Benefit _____ Hours Worked Per Week _____

Employee Address (Mailing) _____

Disability Information

Date employee last worked ___/___/___ Date employee returned to work: (Attach physician's release statement) Fulltime ___/___/___ Parttime ___/___/___

Date employee last worked due to disability ___/___/___ Prior to disability was the employee on: ❑ FMLA ❑ Vacation ❑ Other _____

Is illness/injury work related? ❑ Yes ❑ No If yes, has a workers comp claim been or will be filed? ❑ Yes ❑ No Job Title _____

Job Duties (be specific or attach job description

_____

Limitations of job duties due to disabilities _____

_____

_____

Can the job be modified to accommodate the disability either temporarily or permanently?

❑ Yes ❑ No Explain _____

Signature of Authorized Representative _____ Date _____

Print Name of Authorized Representative _____

TO BE COMPLETED BY EMPLOYEE

Description of illness/injury _____ Date of illness/injury ___/___/___

Were you at work? ❑ Yes ❑ No Is accident work related? ❑ Yes ❑ No

Physician's Name _____ Phone Number _____ Specialty _____

Address _____ Fax Number _____

Date(s) seen by physician ___/___/___ ___/___/___ ___/___/___ ___/___/___

Physician's Name _____ Phone Number _____ Specialty _____

Address _____ Fax Number _____

Date(s) seen by physician ___/___/___ ___/___/___ ___/___/___ ___/___/___

Were you admitted to the hospital? ❑ Yes ❑ No

Name of Hospital _____ Phone Number _____

Address _____ Fax Number _____

Date of admit/discharge ___/___/___ - ___/___/___

~over~

TO BE COMPLETED BY PHYSICIAN

Name of Patient _____ Patient's condition is a result of: ❑ Illness ❑ Injury ❑ Pregnancy

If pregnancy – expected date of delivery ___/___/___ Is condition due to patient's employment ❑ Yes ❑ No

Primary Diagnosis _____ ICD Code _____

Secondary Diagnosis _____ IDC Code _____

Subjective Symptoms _____

Date symptom first appeared or accident occurred ___/___/___ Date patient first consulted you for this condition ___/___/___

Date of visit(s)/treatments for this condition _____

Date of next visit ___/___/___ Has surgery been performed ❑ Yes ❑ No Date of Procedure ___/___/___

Type of procedure(s) _____ Length of recovery _____

CPT Code(s) _____ Prognosis _____

Plan of Treatment _____

Limitations for patient from this illness/injury (Be Specific)

❑ Walking ❑ Sitting ❑ Standing ❑ Lifting/Carrying ❑ Keyboard Use/repetitive hand motion

❑ Vision ❑ Climbing Stairs ❑ Driving ❑ Reaching/Working Overhead ❑ Pushing/Pulling

❑ Other _____

Date patient became unable to work due to this condition ___/___/___

Date(s) patient became unable to perform job duties due to this condition From: ___/___/___ to: ___/___/___

Date patient should be released to return to work _____ Is the patient still under your care? ❑ Yes ❑ No

Was patient referred to you from another physician? ❑ Yes ❑ No If yes, name/address of physician(s)

Name _____

Address _____ Phone _____

Has patient been referred to another physician? ❑ Yes ❑ No If yes, name/address of physician(s)

Name _____ Name _____

Address _____ Address _____

Phone _____ Phone _____

PLEASE PRINT/TYPE

Physician Information

Physician Name _____ Phone Number _____

Address _____ Fax Number _____

Social Security Number or EIN _____ Degree/Specialty _____

Signature Date

FRAUD STATEMENT - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an enrollment form or application for insurance is guilty of a crime and may be subject to fines and confinement in prison.