



INSTRUCTIONS

This form is to be completed by the employee, attending physician, and the employer or Plan Administrator. To avoid delay in processing your claim, please make certain each statement is dated and signed. The completed form should be submitted to the Home Office as soon as possible.

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime

EMPLOYEE'S STATEMENT

Employee's name		Date of birth	Sex	Social Security number
Residence address	Street	City or town	State	Zip
Home phone number ()				Occupation
Employer	Business address			Occupation
Date of sickness	Date of accident	Date of first treatment		
Nature of sickness or injuries				
If injury, how and where did accident happen?			Did disability result from employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date last worked	Date you first resumed any duties	If not resumed, when do you expect to?		
If still disabled, describe present activities				
Names and addresses of physicians				
I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person who has attended me or has any records or knowledge of me or my health to furnish the Security Mutual Life Insurance Company of New York, or its representative, any and all information with respect to any illness or injury, medical history, consultations, prescriptions, or treatment, and copies of all hospital and medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.				
Date _____ Signed _____				

EMPLOYER OR PLAN ADMINISTRATOR'S STATEMENT

Employee's name		Date employed	Policy number
Effective date of employee's insurance		Classification	Termination date of insurance
Job title and brief description of duties		Average weekly wage	Did disability result from employment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date last worked	Reason for leaving	Date returned to work	Employer's phone number ()
Percentage of premium paid by employER _____ %. (If unanswered, we will assume 100% of employER contribution.)			
Date	Signed		Title
Name of firm	Business address		Zip



PHYSICIAN OR SUPPLIER INFORMATION

1. Patient's name (First name, middle initial, last name)	Date of Birth
2. Diagnosis or nature of illness or injury 1. 2. 3.	
3. Date of illness (first symptom) OR injury (accident) OR pregnancy (LMP)	
4. Date first consulted you for this condition	
5. Has patient ever had same or similar symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Was condition related to: A. Patient's Employment? <input type="checkbox"/> Yes <input type="checkbox"/> No B. Accident <input type="checkbox"/> Auto <input type="checkbox"/> Other _____	
7. Dates of total disability from _____ through _____	Dates of partial disability from _____ through _____
8. Date patient able to return to work	
9. Name of referring physician	
10. For services related to hospitalization, give hospitalization dates Admitted _____ Discharged _____	
11. Name & address of facility where services rendered (if other than home or office)	
12. Signature of physician or supplier	Date signed
13. Your Social Security number	
14. Your license number	
15. Physician's or supplier's name, address & telephone number	