DISABILITY CLAIM FORM

Mail claims to:
Fringe Benefit Coordinators
P O BOX 771
Kathleen, FL 33849

FRINGE BENEFIT COORDINATORS

P O Box 771
Kathleen, FL 33849
(352) 377-1239 Fax (352) 372-9805
WWW.FBC-INC.COM

PART 1 EMPLOYEE STATEMENT — PLEASE REFER TO INSTRUCTIONS BELOW

EMPLOYEE NAME	SOCIAL SECURITY # XXX-XX-	NAME OF DISTRICT BRADFORD
EMPLOYEE MAILING ADDRESS	EMPLOYEE BIRTH DATE	OCCUPATION / GROUP NUMBER 7033
CITY STATE ZIP	PHONE NO.	EMAIL ADDRESS (OPT) / NAME OF SCHOOL

IS DISABILITY DUE TO ☐ ACCIDENT ☐ SICKNESS ☐ PREGNANCY — IS CONDITION WORK RELATED? ☐ YES ☐ NO

DESCRIBE THE INJURY INCURRED (WHAT, WHERE, HOW) OR THE NATURE AND DETAILS OF THE SICKNESS AND WHEN IT BEGAN:

DATE OF ACCIDENT OR SICKNESS :	LAST DATE WORKED:	PREVIOUSLY TREATED FOR THIS INJURY OR ILLNESS? ☐ YES ☐ NO
HAVE YOU RETURNED TO WORK? ☐ YES ☐ NO	IF YES, WHAT DATE?	☐ FULL-TIME ☐ PART-TIME

EMPLOYEE MUST SIGN AND DATE BELOW

AUTHORIZATION TO RELEASE INFORMATION
I hereby authorize any insurance company, prepayment organization, third party payor, employer hospital or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits for service. I hereby certify the information provided is correct and true to the best of my knowledge.

X_____ _____
EMPLOYEE SIGNATURE — Date

PART 2 TO BE COMPLETED BY PHYSICIAN

DOCTOR'S NAME & DEGREE	DOCTOR'S SPECIALTY
ADDRESS	CITY STATE ZIP
PHONE NUMBER	DATE OF FIRST CONSULTATION FOR THIS CONDITION? ICD-9:
IS PATIENT STILL UNDER YOUR CARE? ☐ YES ☐ NO	PATIENT WAS UNABLE TO WORK FROM THROUGH
IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK:	HOURS PER WEEK:
PHYSICIANS SIGNATURE	DATE

HOSPITAL INCOME

HOSPITAL NAME	HOSPITAL PHONE NUMBER
ADDRESS	CITY STATE ZIP
DATES OF CONFINEMENT — FROM TO	PROOF OF CONFINEMENT ATTACHED? ☐ YES ☐ NO

PROCEDURE FOR FILING A CLAIM

1. Complete and sign the "Employee Statement" section of the form (Part #1).
2. Have your doctor complete PART 2 for each claim.
3. Take completed form to the HR office of your employer
4. For Hospital Income claim, please complete Hospital name and address.
5. Attach copy of hospital bill showing dates of confinement