INCOME PROTECTION PLAN
FOR
EVERGREEN TEACHERS ASSOCIATION

Claim Statement of Employee

Return completed form to:

United Administrative Services
P.O. Box 5057 - Zip:95150
1120 South Bascom Ave. Phone No. (408) 288-4400
San Jose, California 95128

PART I To be completed by Employee

Full Name _____ Date of Birth _____

Address _____ City & State _____ Zip _____

Phone No. _____ Occupation _____

Regular Monthly Salary _____ S.S. No. _____

Last day worked before disability began: _____

Date accident occurred or sickness began	
Nature of sickness or injury	
Is condition due to injury or sickness arising out of employment?	
If sickness, when were first symptoms noticed?	
If injured, how and where did the accident occur?	
Name and address of physician (Give names of all physicians consulted)	
Date first treated	
Have you been confined to a hospital?	Admitted Discharged
Name and Address of hospital	
On what date did you or do you expect to resume your usual duties?	

Have you or do you intend to file this claim under Worker's Compensation? Yes ☐ No ☐

Have you or do you intend to file for Public Employees' Retirement Benefits or STRS Disability Benefits Yes ☐ No ☐

If yes, please indicated amount

I hereby authorize any hospital, physician, or other person who has attended me or examined me to disclose when requested to do so by United Administrative Services, any and all information with respect to any illness or injury, medical history, consultation, prescription, or treatment, and copies of all hospital or medical records. A photocopy of this authorization shall be considered as effective and valid as the original.

Dated _____ Signed _____

PART II Attending Physician's Statement

DIAGNOSIS AND CONCURRENT CONDITIONS
(If diagnosis code other than ICDA* used, give name):

IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT?
YES ☐ NO ☐

PREGNANCY?
YES ☐ NO ☐

If Yes, approximate date pregnancy commenced.
DATE

REPORT OF SERVICES (Or attach itemized bill) (If previous form submitted to this carrier, you need show only dates and services since last report)

DATE OF SERVICES	PLACE OF SERVICES†	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE — IF USED (If code other than CPT** used, give name)	CHARGES

†O—Doctor's Office IH—Inpatient Hospital NH—Nursing Home
H—Patient's Home OH—Outpatient Hospital OL—Other Locations
*ICDA—International Classification of Diseases
**CPT—Current Procedural Terminology (current edition)

TOTAL CHARGES ▸ $
AMOUNT PAID ▸ $
BALANCE DUE ▸ $

DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED.

DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION.

PATIENT EVER HAD SAME OR SIMILAR CONDITION?
YES ☐ NO ☐ If "Yes" when and describe:

PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?
YES ☐ NO ☐

PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (Unable to work).
From Thru

PATIENT WAS PARTIALLY DISABLED.
From Thru

IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK.

PATIENT WAS HOUSE CONFINED.
From Thru

DOES PATIENT HAVE OTHER HEALTH COVERAGE?
YES ☐ NO ☐ If "Yes" please identify

TAXPAYERS IDENTIFICATION NUMBER

Date Physician's Name (Print) Signature Degree Telephone

Street Address City or Town State Zip Code

Approved by Council on Medical Services, AMA 10-67

I authorize the release, to United Administrative Services, of any and all medical records pertaining to the above patient.

Signed _____ Degree