

MUNICIPAL HEALTH BENEFIT FUND
PO Box 188
North Little Rock, AR 72115

Disability Income Claim Form

Employee Instructions:

1. This form is to be filed as soon as you become disabled and qualify for disability benefits.
2. Complete the "Statement of Employee" below.
3. Your Physician must complete the "Physician's Statement of Disability" on the reverse side.
4. **Please note that claims will not be considered for more than four (4) weeks at a time. An updated Physician Statement will be required for benefits to continue.**
5. Return this form to the address above.
6. Be sure to notify MHBF as soon as you return to work.

Statement of Employee:

Employee Name _____ Telephone Number _____

Occupation _____ Date of Birth / / Social Security Number / /

When did you become wholly unable to work? _____ AM/PM
Date / / Time _____

Is disability due to an _____ accident or _____ illness? If an accident, please describe, including date and place accident occurred: _____

If an illness, when did symptoms first appear? _____

Have you been hospitalized? _____ Yes _____ No If so, when? From / / To / /

Please list name and location of hospital: _____

Did disability result from your employment? _____ Yes _____ No

If you have other disability insurance coverage, please list the name(s) of the carrier(s), along with policy numbers:

Company Name _____ Policy Number _____

Company Name _____ Policy Number _____

I attest that these statements are true and complete to the best of my knowledge. I authorize any insurer, physician or hospital to disclose any information regarding my insurance coverage or medical history.

Employee Signature _____ Date / /

Address: _____
City _____ State _____ Zip _____

