



# Disability Plans Disability Claim Form

- Short term Disability  
 Long term Disability

## EMPLOYEE INFORMATION

<b>NAME:</b> Last First MI			Employee ID #:	
<b>HOME ADDRESS:</b> Street Apt. City State Zip				
<b>DATE OF BIRTH:</b>		<b>HOME PHONE:</b>		<b>GENDER:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female

I authorize any licensed physician who has examined or treated me to release any or all necessary information and records to Northwestern University upon its written request, for the purpose of determining my medical condition and eligibility for disability benefits. I also authorize Northwestern University to require me to see a physician designated by Northwestern University and acknowledge that my failure to see the Northwestern University designated physician will cause the termination of my disability benefits.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## PHYSICIAN INFORMATION

<b>NAME:</b>		<b>OFFICE PHONE:</b>	<b>FAX:</b>
<b>ADDRESS:</b> Street City State Zip			

## MEDICAL INFORMATION

**Failure of the physician to provide full and complete information or to respond in a timely manner to follow-up inquiries from Northwestern University will cause a delay in or cancellation of disability benefits for the patient.**

Is this <input type="checkbox"/> an original claim? <input type="checkbox"/> an extension of a previous claim? <input type="checkbox"/> a work related injury?		
Primary Diagnosis:		Diagnosis Code:
Date of illness or injury (first diagnosis):	Date diagnosed as totally disabled:	Date of next examination:
Prognosis (is patient expected to recover; if so, when?; etc)::		
What are the patient's present limitations? (be specific).		
Date patient will be able to return to work:		

I certify that I have personally examined the above patient and the information contained in this form is true and accurate to the best of my knowledge.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date