MERITAIN HEALTH
An Aetna Company

Short Term Disability Claim Form

ALL questions must be answered to avoid a possible delay. Claims are subject to review to determine medical appropriateness.

Please fax completed claim form to 716-319-5784 or email to disability@meritan.com

Employee's Statement of Claim — *Please Print*

Full Name	Social Security Number	Phone Number	
Mailing Address (if different from street address)	City	State	Zip Code
Employer Name Plumbers & Fitters Local No. 101	Email address (optional)		
Date of Birth:	Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced	Gender: ☐Male ☐Female	
Is the claim a result of a work related illness or injury? ☐Yes ☐No	Is claim due to an accident/injury? ☐Yes ☐No		
Have you or will you file a claim for workers compensation benefits? ☐Yes ☐No	Please provide a detailed description of how injury occurred and location.		
Date Disability commenced	Date disability ceased		
Have you filed for Social Security Benefits? ☐Yes ☐No	Date that claim was filed:	Date that Social Security benefits commenced:	

Authorization to Release Information: I hereby authorize any providers or Health Care services, claim administrators, insurers, reinsurers and others who have legitimate need for such information for the purpose or review, investigation or evaluation of a claim, to supply each other with information about my health status and the health care services provided to me. I agree that a photographic copy of this authorization is as valid as the original.

_____ Employee Signature

_____ Date

Important notice to all employees: Time spent on short-term disability leaves of absence (including any waiting periods) will be deducted from your 12-week leave bank in accordance with the Family Medical Leave Act of 1993

_____**Employee initials**

Any person who knowingly and with intent to defraud any insurance company or claims administrator or other person files an application for insurance or 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 initials**

Attending Physician's Statement — *Please Print*

Diagnosis	ICD10 Code	Disability due to pregnancy? ☐Yes ☐No	Expected delivery date:
Is Disability due to illness or injury arising from Patient's employment? ☐Yes ☐No	Auto related? ☐Yes ☐No	Date of first treatment:	Date of most recent treatment: Date of next appointment:
Describe course of treatment:			Was the patient hospital confined? ☐Yes ☐No From: Through:
The patient has been continuously disabled (unable to work) From: Through:	The patient should be able to work on/or about: (Please indicate a specific date to avoid a delay in benefits)		Date and type of surgical procedure:
Attending Physician (please print)	Physician's signature (no stamped signatures)		Physician specialty:
Physician's address:	Telephone number: Fax number:		Date: