



Request For Benefits Disability Income

BeniComp Inc.
8310 Clinton Park Dr.,
Ft. Wayne, IN 46825

(260) 482-7400 ■ 1-800-837-7400

EMPLOYER

Employer: Give form to employee as soon as possible for completion of Employee and Physician portions. Forward completed Request For Income to Claim Office after you have completed Employer portion. Benefits will be paid weekly.

Employee's Name (active employee)			Employee Social Security Number	
Last	First	Middle Initial		

Patient's Date of Birth			Date Employed:		
Month	Day	Year	Month	Day	Year

Address:

Present Weekly Wage:	Employee Occupation	Date Last Worked
		Month / Day / Year

Date Disability Began:	If back to work, Date Returned:	Division or Location #
Month / Day / Year	Month / Day / Year	

Class #	Amount of Weekly Indemnity	Amount of Federal Income Tax to be Withheld
	\$	\$

Claim Statement Furnished To Employee For Completion On:

Is There Any Other Reasons Which May Delay The Employee's Return to Work? (explain)

Yes No

EMPLOYEE

Signature

Title