



Wage Replacement Disability Income Statement

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

(260) 482-7400 ■ 1-800-837-7400

EMPLOYEE	INSTRUCTIONS TO EMPLOYEE: Your Plan provides weekly benefits while you are totally disabled from your usual occupation, under the care of a physician, and your physician certifies that you are disabled. Please complete the employee's portion completely and give to your doctor for completion of the physician's portion and mailing to the address shown on the form. Completion and return of the form is necessary for your benefits to be paid.		
	Employee's Name (Please Print Full Name)		Employee's Social Security Number
	Last	First	Middle Initial
	Address		Employee's Date of Birth
	City		State
	Zip		What is your general condition at this time?
	<input type="checkbox"/> Improving <input type="checkbox"/> Unchanging <input type="checkbox"/> Recovered <input type="checkbox"/> Comments:		<input type="checkbox"/> Walking <input type="checkbox"/> Standing <input type="checkbox"/> Lifting <input type="checkbox"/> Transportation
Date of your next appointment?		On what day do you estimate you will be able to return to work?	
I hereby certify to the accuracy of the above statements.			
Employee Signature		Date	

PHYSICIAN	Patient's Name		Cause of present disability and concurrent conditions affecting disability:	
	Last	First	Middle Initial	Work Related?
	<input type="checkbox"/> Yes <input type="checkbox"/> No		Expected delivery date?	
	FEMALE PATIENTS Disability related to pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does Employee have complications due to pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Date conditioning became disabling?		Date of first treatment?	
	Month / Day / Year		Month / Day / Year	
	Frequency of treatment			
	<input checked="" type="checkbox"/> X a day		<input checked="" type="checkbox"/> X a week	
	<input type="checkbox"/> X a month		<input type="checkbox"/> Other	
	Date of last treatment?		Next scheduled visit?	
	Month / Day / Year		Month / Day / Year	
	Type of Treatment rendered		Date admitted to hospital:	Date discharged:
	Month / Day / Year		Month / Day / Year	Month / Day / Year
	Progress: <input type="checkbox"/> Recovered <input type="checkbox"/> Improved <input type="checkbox"/> Unchanged <input type="checkbox"/> Retrogressed		Employee is: <input type="checkbox"/> Ambulatory <input type="checkbox"/> House confined <input type="checkbox"/> Bed Confined <input type="checkbox"/> In Hospital	
Temporary TOTAL disability from:	Thru/incl	Temporary PARTIAL disability from:	Thru/incl	
Month / Day / Year	Month / Day / Year	Month / Day / Year	Month / Day / Year	
Date may return to LIGHT duty	What are specific work restrictions?	Date may return to REGULAR duties	Are you reporting this disability to any other Insurance co.?	
Month / Day / Year		Month / Day / Year	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Name & Degree		Phone #	Tax I.D. #	
Address		Comments		

Physician's/Surgeon's Signature

Date

