SET SEG
School Insurance Specialists

LONG TERM DISABILITY CLAIM STATEMENT

TO BE COMPLETED BY EMPLOYEE

CLAIMANT

FULL NAME (LAST, FIRST, MIDDLE INITIAL) | SOCIAL SECURITY NUMBER | PHONE

ADDRESS | CITY | STATE | ZIP

Date of birth:_____/_____/_____ Height:_____ Weight:_____ Sex: ☐ M ☐ F

Marital status: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

Spouses date of birth:_____/_____/_____ Spouse name:_____ Is spouse employed? ☐ YES ☐ NO

Number of children (under age 19):_____ List names and dates of children of birth of unmarried children who have not finished high school:

EMPLOYMENT

☐

EMPLOYER'S NAME | GROUP POLICY NUMBER

OCCUPATION (LIST THE DUTIES OF YOUR OCCUPATION AT THE TIME OF DISABILITY)

DO YOU OR DID YOU HAVE A PART-TIME JOB? IF SO, PLEASE GIVE NAME AND ADDRESS OF EMPLOYER AND DESCRIBE YOUR JOB.

Date of accident or date you first noticed symptoms of illness:_____/_____/_____

I have been unable to work because of the disability since:_____/_____/_____

I returned to work on a part-time basis on: _____/_____/_____ I returned to work on a full-time basis on_____/_____/_____

Is your accident or illness related to your occupation? ☐ YES ☐ NO If yes, explain:_____

Have you or do you intend to have a workers' compensation claim? ☐ YES ☐ NO

CLAIM HISTORY

Describe how and where accident occurred or describe the onset and nature of your illness:_____

How does it prevent you from working:_____

Date you were first treated for your illness or injury:_____/_____/_____ Treated by (lines below must be completed):

HOSPITAL NAME | ADDRESS | CITY | STATE | ZIP

DOCTOR NAME | ADDRESS | CITY | STATE | ZIP

Have you ever had the same or similar injury in the past? ☐ YES ☐ NO (If yes, lines below must be completed):

HOSPITAL NAME | ADDRESS | CITY | STATE | ZIP

DOCTOR NAME | ADDRESS | CITY | STATE | ZIP

INCOME

Describe other income you are receiving:

TYPE	AMOUNT	DATE BEGAN	DATE TERM.
Social Security (disability or retirement)	$_____	_____/_____/_____	_____/_____/_____
State disability	$_____	_____/_____/_____	_____/_____/_____
Retirement (normal, early, or disability)	$_____	_____/_____/_____	_____/_____/_____
Workers' Compensation	$_____	_____/_____/_____	_____/_____/_____
Group disability benefits	$_____	_____/_____/_____	_____/_____/_____
Other (describe):_____	$_____	_____/_____/_____	_____/_____/_____

BENEFIT

Have you, or do you plan to apply for benefit described in the list above? ☐ YES ☐ NO

Type:_____ Date application filed:_____/_____/_____

Type:_____ Date application filed:_____/_____/_____

SIGNATURE

The above statements are true and complete to the best of my knowledge and belief.

EMPLOYEE SIGNATURE | DATE

Send completed form to: SET, Inc. | Attn Life & Disability Claims
415 W. Kalamazoo St. Lansing, MI 48933-2079 | Fax (517) 482-4181

REV. 8/20/15

Phone: (800) 292-5421 | Email: customerservice@setseg.org

SET SEG
School Insurance Specialists

EMPLOYER'S REPORT TO CLAIM

TO BE COMPLETED BY EMPLOYER

CLAIMANT

EMPLOYEE'S NAME _____ SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMPLOYMENT

Insurance class:_____ Employee date of hire:_____/_____/_____ Date employee became insured for LTD:_____/_____/_____

Date employee was actually last present at work and did normal duties:_____/_____/_____

JOB TITLE _____ JOB DESCRIPTION _____

Work schedule when last worked: Number of days per week:_____ Number of hours per day:_____

Reason for stopping work: ☐ SICKNESS ☐ RETIRED ☐ RESIGNED ☐ VACATION ☐ LAID OFF ☐ GRANTED LOA ☐ DISMISSED ☐ OTHER

Has employee returned to work for you or another employer? ☐ YES ☐ NO ☐ PART-TIME DATE_____ ☐ FULL-TIME DATE_____

INCOME

How is employee paid:

☐ STRAIGHT SALARY ☐ SALARY & COMMISSIONS ☐ COMMISIONS ONLY ☐ HOURLY-RATE OF PAY WHEN LAST WORKED:_____ ☐ SALARY & BONUS

Employee's basic monthly earnings: $_____ (IF SALARY IS BASED ON LESS THAN 12 MONTHS - NUMBER OF MONTHS _____)

OTHER BENEFITS

Has insured received other disability payments since time last worked?

A) Salary Continuance:
☐ YES Wkly. Amt:_____
Date benefits cease:_____
☐ NO

B) Insured Short Term:
☐ YES Wkly. Amt:_____
Date benefits cease:_____
☐ NO

C) Other Type:
☐ YES Wkly. Amt:_____
Date benefits cease:_____
☐ NO

Did claim result from job activity? ☐ YES ☐ NO If yes, explain:_____

Has a workers' compensation claim been filed? ☐ YES ☐ PENDING ☐ DENIED (ENC. COPY)

Gross amount of workers weekly compensation: $_____ (INCLUDE COPY OF 1ST REPORT OF ACCIDENT)

RETIREMENT

Is employee covered by employer sponsored retirement plan? ☐ YES ☐ NO Does retirement plan contain a disability provision? ☐ YES ☐ NO

Is employee or will this employee be eligible for a disability or retirement pension? ☐ YES ☐ NO If yes, type:_____

Monthly amount: $_____ ☐ DISABILITY ☐ RETIREMENT ☐ OTHER_____

Start date of benefits:_____/_____/_____ (ENCLOSE COPY OF SUMMARY PLAN DESCRIPTION)

When will employee be eligible for disability or retirement pension:_____/_____/_____

NOTE: If any portion of this pension benefits is attributable to the employee's contribution, please provide details including the percentage of his/her contribution to the total contribution.

CERTIFICATION

EMPLOYER'S NAME (STATE ASSOCIATION AND NAME OF POLICYHOLDER, IF OTHER) _____ PHONE _____ GROUP POLICY NUMBER _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

Employer I.D. Number (EIN): _____ OR Public Employer Social Security No. 69: _____

NAME OF PERSON COMPLETING THIS FORM _____

EMPLOYEE SIGNATURE _____ DATE _____

SIGNATURE OF AUTHORIZED INSURANCE REPRESENTATIVE _____ TITLE _____ DATE _____

Separate and send this form (with other enclosures) to:
SET, Inc. | Attn: Life & Disability Claims | 415 W. Kalamazoo St. | Lansing, MI 48933-2079 or fax to: (517) 482-4181
Give remaining portions of form to claimant for completion.

REV. 8/20/15

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ATTENDING PHYSICIAN STATEMENT

TO BE COMPLETED BY EMPLOYER

HISTORY

PATIENTS NAME _____ DATE OF BIRTH _____

Date symptoms first appeared or accident happen?_____/_____/_____ Date patient ceased work because of disability:_____/_____/_____

Has patient ever had same or similar condition? ☐ YES ☐ NO If yes, date and describe: _____/_____/_____ _____

Is condition due to injury or sickness arising out of patient's employment? ☐ YES ☐ NO ☐ UNKNOWN

TREATING PHYSICIAN _____ ADDRESS _____

TREATING PHYSICIAN _____ ADDRESS _____

DIAGNOSIS

Diagnosis (including complications):_____

If pregnancy, est. date of delivery: _____/_____/_____ Subjective symptoms:_____

List ICD9 & ICD10 codes:_____

Objective findings (including current x-rays, EKG's, laboratory data and any clinical findings):_____

TREATMENT

Date of first visit: _____/_____/_____ Date of last visit:_____/_____/_____ Frequency of visits: ☐ WEEKLY ☐ MONTHLY ☐ OTHER_____

Nature of treatment (Including surgery and medications prescribed, if any):_____

PROGRESS

Has patient: ☐ RECOVERED ☐ UNCHANGED ☐ IMPROVED ☐ UNCHANGED ☐ RETROGRESSED

Is patient: ☐ AMBULATORY ☐ BED CONFINED ☐ HOUSE CONFINED ☐ HOSPITAL CONFINED Has patient been hospital confined? ☐ YES ☐ NO

If yes, give name and address of hospital and dates:_____ _____/_____/_____

CARDIAC

Functional capacity: ☐ CLASS 1 (NO LIMITATION) ☐ CLASS 2 (SLIGHT LIMITATION) ☐ CLASS 3 (MARKED LIMITATION) ☐ CLASS 4 (COMPLETE LIMITATION)

Blood pressure (last visit): SYSTOLIC_____/ DIASTOLIC_____

IMPAIRMENTS

Physical Impairments (*As defined in Federal Dictionary or Occupational Titles):

☐ CLASS 1 - NO LIMITATION OF FUNCTIONAL CAPACITY; CAPABLE OF HEAVY WORK* NO RESTRICTIONS. (0-10%)
☐ CLASS 2 - MEDIUM MANUAL ACTIVITY* (15-30%)
☐ CLASS 3 - SLIGHT LIMITATION OF FUNCTIONAL CAPACITY; CAPABLE OF LIGHT WORK* (35-55%)
☐ CLASS 4 - MODERATE LIMITATION OF FUNCTIONAL CAPACITY; CAPABLE OF CLERICAL/ADMINISTRATIVE (SEDENTARY*) ACTIVITY. (60-70%)
☐ CLASS 5 - SEVERE LIMITATION OF FUNCTIONAL CAPACITY; INCAPABLE OF MINIMUM (SEDENTARY*) ACTIVITY. (75-100%)

Remarks:_____

Is patient competent to cash check? ☐ YES ☐ NO

PROGNOSIS

Is patient totally disabled? Patients job: ☐ YES ☐ NO Any other work: ☐ YES ☐ NO

Date patient became disabled due to present illness or accident: _____/_____/_____

Expected fundamental or marked change in the future? ☐ 1 MO. ☐ 1-3 MO. ☐ 3-6 MO. ☐ NEVER Applies to: ☐ PATIENT'S JOB ☐ OTHER WORK

REHAB

Is patient a suitable candidate for occupational rehabilitation? ☐ PATIENT'S JOB ☐ OTHER WORK

Can present job be modified to allow for handling with impairment? ☐ YES ☐ NO

When could trial employment commence?

Patient's job: DATE_____/_____/_____ ☐ FULL-TIME ☐ PART-TIME Any other work: DATE_____/_____/_____ ☐ FULL-TIME ☐ PART-TIME

REMARKS

(Limitations, Therapy, etc.) How does this keep the patient from working?_____

SIGNATURE

NAME (ATTENDING PHYSICIAN) _____ DEGREE _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SIGNATURE _____ DATE _____

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