Disability Claim Form

Documentation required upon submitting a Disability Claim:

To substantiate a claim for disability benefits covered by the Policy terms, the following documents must be submitted:

- Disability Claim Form;
- An official document proving the date of birth of the Insured Person (i.e. Passport);
- Proof of employment at date of accident, or first manifestation of illness;
- Proof of salary, if benefit is salaryrelated;
- A detailed medical report from the attending physician(s) on the onset, course and consequences of the bodily injury, disease or accident, as the case may be, as well as the degree and probable duration of the disability.

Underwriters may request further documentation at any time and also have the Insured Person examined by its own medical consultants.

During the continuance of a period of disability, updated medical reports from the attending physician(s) may be requested as often as Providers may reasonably require.

Providers will pay the insured benefit as soon as it has satisfied itself of the validity of the claim based on its assessment of the required documents that have been received.

Claim Form and Documents are accepted via email or fax – hard copy upon request. Submit to:

Email: DisabilityClaims@gbg.com
Fax: +1.949.470.2110
Mail: Global Benefits Group
ATTN: Disability Claims
27422 Portola Parkway, Suite 110
Foothill Ranch, CA 92610 USA

PART I. TO BE COMPLETED BY EMPLOYER OR ORGANIZATION	
A. INSURED INFORMATION	
Name (Last, First, MI):	
Date of Birth: (DD/MMM/YYYY, i.e., 23/NOV/1988)	Employee # (if applicable):
Passport #:	Passport Country of Issuance:
Address:	
Postal Code:	Country:
Phone:	Fax:
Email:	
Occupation:	

B. EMPLOYER INFORMATION	
Company:	
Address:	
Postal Code:	Country:
Group #:	
Effective Date of Insurance (DD/MMM/YYYY):	

C. CLAIM INFORMATION	
Date last worked (DD/MMM/YYYY):	Date returned to work (DD/MMM/YYYY):
Did Disability occur due to occupational causes? ☐ Yes ☐ No	
Monthly salary (at time of disability):	Percent of premium paid by Employee:
Has employment been terminated? ☐ Yes ☐ No	If yes, date (DD/MMM/YYYY):
If yes, reason:	

D. AUTHORIZATION	
Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.	
Signature:	
Name:	
Title:	
Email:	Date (DD/MMM/YYYY):

PART II. TO BE COMPLETED BY CLAIMANT	
A. INSURED INFORMATION	
Name of Insured (Last, First, MI):	
Date of Birth: (DD/MMM/YYYY, i.e., 23/NOV/1988)	
Communications regarding the status of your claim, explanation of benefits and requests for information will be sent to you by email. Please confirm your email address and phone number where you can be best reached.	
Email:	
Phone:	
B. CLAIM INFORMATION	
Date when injury, disability due to sickness or disability due to natural causes first occurred (DD/MMM/YYYY):	
If the disability was caused by an accident, please provide details including date, location and circumstances:	
Has this claim been filed with any other insurance carrier? ☐ Yes ☐ No If yes, please fill in the following:	
Policyholder Name:	
Policyholder Address:	
Postal Code:	Country:
C. AUTHORIZATION	
In connection with this disability claim, I hereby authorize any doctor, past or present, which at any time has attended to me concerning anything which affects my physical or mental health, to release medical information to the underwriters. I agree that a copy of this consent shall have the validity of the original. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.	
Name:	
Signature:	
Date (DD/MMM/YYYY):	

PART III. ATTENDING PHYSICIAN'S STATEMENT

A. PATIENT INFORMATION

Name of Patient (Last, First, MI):
Date of Birth: (DD/MMM/YYYY, i.e., 23/NOV/1988)
Additional details regarding diagnosis and current condition:
Is condition due to injury or sickness arising from Patient's occupation? ☐ Yes ☐ No
Date symptoms first appeared or accident occurred (DD/MMM/YYYY):
Has Patient ever had same or similar condition? ☐ Yes ☐ No If yes, please provide date and details:
If condition is related to pregnancy, please provide estimated delivery date (DD/MMM/YYYY):
Patient was continuously disabled and totally unable to work from (DD/MMM/YYYY):_____through (DD/MMM/YYYY):_____
Patient was partially disabled from (DD/MMM/YYYY):_____through (DD/MMM/YYYY):_____
If still disabled, Patient should be able to return to work (DD/MMM/YYYY):
Date(s) of Treatment (DD/MMM/YYYY):
Was surgery performed? ☐ Yes ☐ No If yes, please provide date and type of procedure:
Was your Patient confined to a hospital: ☐ Yes ☐ No
If yes, dates of confinement from (DD/MMM/YYYY):_____through (DD/MMM/YYYY):_____
Hospital Name:
Address:

Postal Code:	Country:

B. PHYSICIAN INFORMATION		
Physician Name:		
Address:		
Phone:	Country:	
Fax:	Email:	
Physician Signature and Stamp:		Date (DD/MMM/YYYY):

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- Mail: Global Benefits Group,
  ATTN: Teri Frank
  27422 Portola Parkway, Suite 110
  Foothill Ranch, CA 92610 USA