Service Employees Benefit Fund

P. O. Box 1240
Syracuse, NY 13201
(315) 218-6513 • (855) 835-9720
Fax (315) 701-0686

Supplemental Disability Claim Form

PART A – TO BE COMPLETED BY EMPLOYEE

1. Name _____ 2. Birthdate_____

3. Address _____
Street City State Zip Code

4. Social Security No. _____ 5. Telephone No. _____

6. My Disability is _____

7. Is this disability due to an accident/injury? If yes how, when & where did the accident occur? _____

_____

8. Date you last worked? _____

9. Have you returned to work? _____ If yes, what date? _____

I agree to notify SEBF of my return to work date in a timely manner. I understand that I will be responsible for reimbursing SEBF for any overpayment made for days paid after I have been released to return to work.

Employee signature_____ Date_____

PART B – TO BE COMPLETED BY THE EMPLOYER

1. From what date was the employee continuously employed? _____

2. On what date did the employee last work prior to the disability? _____

3. Is the disability the result of an Occupational illness or injury? _____

4. Has the employee returned to work? _____ If yes, on what date? _____

5. Name of employer _____ 6. Telephone No. _____

7. Completed by_____ 8. Date _____

PART C – TO BE COMPLETED BY THE PHYSICIAN

1. Nature of Illness or Injury _____

2. Date of first treatment _____3. Date of most recent treatment_____

4. Date the patient has been continuously disabled _____

5. If still disabled when should the patient be able to return to work _____

6. Physicians Name _____ 7. Telephone No. _____

8. Physicians Signature _____ 9. Date _____

Mail or Fax completed form within 30 days after you become disabled to the above address or fax.