THIS DOCUMENT IS FORM FILLABLE

Clear Form

GROUP INSURANCE
DISABILITY
CLAIM FORM

SECURITY MUTUAL LIFE
INSURANCE COMPANY OF NEW YORK
SECURITY MUTUAL BUILDING • 100 COURT ST.
P.O. BOX 1625 • BINGHAMTON, NY 13902-1625
888-722-8645 • www.securebenefitsolutions.com

Security Mutual…Your Partner for Life.℠

Mail completed form to:
Group Claims
Security Mutual Life Insurance Company of New York
PO Box 1625 • Binghamton, NY 13902-1625

INSTRUCTIONS

This form is to be completed by the employee, attending physician, and the employer or Plan Administrator. To avoid delay in processing your claim, please make certain each statement is dated and signed. The completed form should be submitted to the Home Office as soon as possible ***after*** *the disability begins.*

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

EMPLOYEE'S STATEMENT

Employee's name			Date of birth / Sex	Social Security number
Residence address Street	City or Town	State	Zip	Home phone number ( )
Employer	Business address			Occupation
Date of sickness	Date of accident		Date of first treatment	
Nature of sickness or injuries				
If injury, how and where did accident happen?				Did disability result from employment? ☐ Yes ☐ No
Date last worked	Date you first resumed any duties		If not resumed, when do you expect to?	
If still disabled, describe present activities				
Names and addresses of physicians				

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person who has attended me or has any records or knowledge of me or my health to furnish the Security Mutual Life Insurance Company of New York, or its representative, any and all information with respect to any illness or injury, medical history, consultations, prescriptions, or treatment, and copies of all hospital and medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Date _____ Signed _____

EMPLOYER OR PLAN ADMINISTRATOR'S STATEMENT

Employee's name		Date employed	Policy number
Effective date of employee's insurance		Classification	Termination date of insurance
Job title and brief description of duties		Average weekly wage	Did disability result from employment? ☐ Yes ☐ No
Date last worked	Reason for leaving	Date returned to work	Employer's phone number ( )
Percentage of premium paid by employER_____ %. (If unanswered, we will assume 100% of employER contribution.)			
Date	Signed		Title
Name of firm	Business address		Zip

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PHYSICIAN OR SUPPLIER INFORMATION

1. Patient's name (First name, middle initial, last name)	Date of Birth
2. Diagnosis or nature of illness or injury 1. 2. 3.	
3. Date of illness (first symptom) OR injury (accident) OR pregnancy (LMP)	
4. Date first consulted you for this condition	
5. Has patient ever had same or similar symptoms? ☐ Yes ☐ No	
6. Was condition related to: A. Patient's Employment? ☐ Yes ☐ No B. Accident ☐ Auto ☐ Other _____	
7. Dates of total disability from through	Dates of partial disability from through
8. Date patient able to return to work	
9. Name of referring physician	
10. For services related to hospitalization, give hospitalization dates Admitted Discharged	
11. Name & address of facility where services rendered (if other than home or office)	
12. Signature of physician or supplier	Date signed
13. Your Social Security number	
14. Your license number	
15. Physician's or supplier's name, address & telephone number	

The patient is responsible for securing this form and for charges made for its completion.