SUPPLEMENTARY STATEMENT OF CLAIM

SECURITY MUTUAL LIFE
INSURANCE COMPANY OF NEW YORK
SECURITY MUTUAL BUILDING • 100 COURT ST.
P.O. BOX 1625 • BINGHAMTON, NY 13902-1625
607.723.3551 • www.smlny.com

Mail completed form to:
Group Claims
Security Mutual Life Insurance Company of New York
PO Box 1625 • Binghamton, NY 13902-1625
Fax: 607-773-2276 • Email: GroupClaims@smlny.com

INSTRUCTIONS

This form is to be completed by the employee, employer and the attending physician. Benefits are considered on a bi-weekly basis subject to receipt of required proof of medical evidence by your doctor. To avoid delay, please return the completed form promptly.

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

To be completed by Employee

Employee's Full Name ______________________ Claim No. ______________

Address ______________________________________ Zip Code ________

1. A. Has your doctor discharged you? ☐ Yes ☐ No If yes, give date ______________

   B. If No, date of next appointment ______________________________

2. Has your disability terminated? ☐ Yes ☐ No If yes, give date ______________

3. Show date you returned to work ____________________ OR if still disabled, show expected date of return ____________________ AND describe your present activities

   ____

Date ______________________ Signed ______________________

To be completed by Employer

Has employee returned to work? ☐ Yes ☐ No IF YES, GIVE DATE ______________

If no, what date is the employee expected to return? ______________________

If not returning, when was this employee terminated? ______________________

Date ______________________ Signed ______________________

Name of Employer ______________________ Title ______________________

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Must be completed by Attending Physician

1. Patient's Name ____________________

2. Date of next scheduled appointment ____________________

3. Nature of sickness or injury. (Describe complications, if any) ____________________

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4. If disability is caused by pregnancy, indicate delivery date ____________________ Type ____________________

5. A. Date of first treatment ____________________

   B. Date of most recent treatment* ____________________

   C. Frequency of treatments ____________________

   D. Date of surgery ____________________

   E. Nature of surgery ____________________

   F. Date of final discharge ____________________

6. Dates of total disability: from ____________________ through ____________________

   Dates of partial disability: from ____________________ through ____________________

   Date patient able to return to work ____________________

7. Remarks: ____________________

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Attending Physician's Signature ____________________

Print Attending Physician's Name ____________________

Attending Physician's Address ____________________

____

Attending Physician's Phone Number ____________________

Date ____________________

***Failure to provide this information may delay future benefits.**