MICHIGAN CATHOLIC CONFERENCE

Short Term Disability Application

For MCC Use Only	Date sent MM/DD/YYYY	Date received MM/DD/YYYY

Employee Information *All sections to be completed in full.*

Full name *Last, first, and middle*	SSN *###-##-####*	Date of birth *MM/DD/YYYY*
Address *Street address or PO box, city, state, and zip code*		Phone *(###) ###-####*

If disability is due to an accident, where did it occur? ☐ Home ☐ Work ☐ Other *Provide details requested below.*

Details of how accident occurred	Date *MM/DD/YYYY*
	Time *HH:MM AM or PM*

If injury was the result of a motor vehicle accident… *Provide details requested below.*

Were you the driver? ☐ Yes ☐ No

Was the accident reported to the police? ☐ Yes ☐ No *If 'Yes', provide police department address below.*

Police department address *Street address or PO box, city, state, and zip code*

If your condition is work related, was a Workers' Compensation Benefit Claim filed? ☐ Yes ☐ No *If 'No', provide explanation.*

Explanation

If you are entitled to benefits from any other source… *Provide details requested below. If 'Other', please specify.*

Type of benefit: ☐ Auto insurance ☐ State Disability ☐ Pension plan ☐ Social Security ☐ Retirement ☐ Workers' compensation ☐ Other:

Amount of benefit $	Received: ☐ Weekly ☐ Biweekly ☐ Monthly ☐ Lump sum	Date benefit began MM/DD/YYYY	Date benefit ends MM/DD/YYYY

What physicians have you consulted during your illness? *List any additional physicians on final page of this form.*

Physician name	Reason consulted
Address *Street address or PO box, city, state, and zip code*	Date *MM/DD/YYYY*
Physician name	Reason consulted
Address *Street address or PO box, city, state, and zip code*	Date *MM/DD/YYYY*
Physician name	Reason consulted
Address *Street address or PO box, city, state, and zip code*	Date *MM/DD/YYYY*

At what hospitals have you received treatment during your illness? *List any additional hospitals on final page of this form.*

Hospital name	Date admitted MM/DD/YYYY	Date released MM/DD/YYYY
Address *Street address or PO box, city, state, and zip code*		

Questions? Please contact Michigan Catholic Conference by phone at (800) 395-5565, fax to (517) 316-3690, or mail to 510 South Capitol Avenue, Lansing, Michigan 48933.
Visit us on the web at www.micatholic.org

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Hospital name	Date admitted *MM/DD/YYYY*	Date released *MM/DD/YYYY*
Address *Street address or PO box, city, state, and zip code*		
Hospital name	Date admitted *MM/DD/YYYY*	Date released *MM/DD/YYYY*
Address *Street address or PO box, city, state, and zip code*		

Does your illness still prevent you from returning to work? ☐ Yes ☐ No *If 'Yes', provide date you expect to return. If 'No', provide date you returned.*

Date expected to return / Date returned *MM/DD/YYYY*

Prohibition Against the Commission of Fraud / Authorization for Release of Medical Information *You must sign and date this form for it to be valid.*

PLEASE BE AWARE: Certain states regulate and have laws concerning any person who knowingly and with intent to defraud any company files a statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact, material hereto, commits a fraudulent act, which is a crime, subject to criminal prosecution and civil penalties. **A facsimile or photocopy of this release shall be as valid as if it were an original.**

☐ I hereby authorize any hospital, physician, medical practitioner, clinic, medical facility, pharmacy, employer or insurance company to release any and all reports or information with respect to the medical history, physical condition and treatment rendered to this claimant; and, if required, to permit them or any person appointed by them to examine any and all X-rays or records regarding the physical condition of or treatment rendered to the Plan Administrator, the Michigan Catholic Conference.

Employee signature	Date *MM/DD/YYYY*

Employer Information

Employer Information *All sections to be completed in full.*

Unit name	Unit number *####*
Address *Street address or PO box, city, state, and zip code*	Phone *(###) ###-####*

Supervisor name	Employee occupation	Date last worked *MM/DD/YYYY*

If employee has not returned to work, do you expect them to do so? ☐ Yes ☐ No

If disability is work related, was a Workers' Compensation Benefit Claim filed? ☐ Yes ☐ No

If claim relates to maternity… *Provide dates of leave.*

From *MM/DD/YYYY*	To *MM/DD/YYYY*

Employee Salary Information *'Date of last payment' and 'Amount of last payment' refer to last salary payment or sick pay disbursement.*

PLEASE NOTE: Eligible employees will only receive short term disability benefits ("benefits") during their paid year of employment (i.e., employees on a 10-month pay schedule will receive benefits during that 10-month period; employees on a 12-month pay schedule will receive benefits during that 12-month period). Benefits will cease at the end of the scheduled pay year. If the employees are otherwise entitled to continue receiving benefits at the conclusion of their scheduled pay year, the employees must renew their contracts for benefits to continue at the beginning of the following year. **Employees cannot receive regular wages at the same time they are receiving benefits.**

Annual salary prior to disability	Paid over:	Paid-through date *MM/DD/YYYY*	Amount of last payment
$	☐ 10 months ☐ 12 months		$

Employer Signature *You must sign and date this form for it to be valid.*

NOTE TO EMPLOYERS: Please verify information on the employee statement and ensure that this form has been completed in its entirety. An incomplete form may cause unnecessary delays in the processing of the claim.

Employer signature	Date *MM/DD/YYYY*

Attending Physician's Statement

Patient Information *All sections to be completed in full.*

Patient name	Age

Diagnosis

Describe additional conditions which may affect the patient's duration of disability

Date of first visit *MM/DD/YYYY*	Date of last visit *MM/DD/YYYY*	Estimated frequency of future visits: ☐ Weekly ☐ Monthly ☐ Other:

Have you been actively supervising this patient's care during the full period? ☐ Yes ☐ No *If 'No', comment below in 'Remarks'.*

Was the patient referred to you by another physician? ☐ Yes ☐ No *If 'Yes', provide details requested below.*

Physician name	Phone *(###) ###-####*

Has the patient had any surgery? ☐ Yes ☐ No *If 'Yes', provide details requested below.*

Hospital name	Date admitted *MM/DD/YYYY*	Date released *MM/DD/YYYY*

Address *Street address or PO box, city, state, and zip code*

Type of surgery performed	Date performed *MM/DD/YYYY*

Is the patient's condition a result of a work related injury or illness? ☐ Yes ☐ No

To the best of my knowledge, the patient has been totally disabled (unable to work). ☐ Yes ☐ No
If 'Yes', provide how long the patient was or will be been totally disabled. If still disabled, also provide approximate date patient should be able to return to work.

Date from *MM/DD/YYYY*	Date to *MM/DD/YYYY*	Approximate date of return *MM/DD/YYYY*

Was or is the patient partially disabled? ☐ Yes ☐ No *If 'Yes', provide how long the patient was or will be partially disabled.*		**If condition is due to pregnancy, was is or was the expected date of confinement?**	**To the best of my knowledge, date symptoms first appeared or accident happened.**
Date from *MM/DD/YYYY*	Date to *MM/DD/YYYY*	Date *MM/DD/YYYY*	Date *MM/DD/YYYY*

Has the patient previously had the same or a similar condition? ☐ Yes ☐ No *If 'Yes', provide details requested below.*

Date *MM/DD/YYYY*	Description

Remarks

Physician Information

Physician name	Specialty

Address *Street address or PO box, city, state, and zip code*	Phone *(###) ###-####*

Physician Signature *Please return completed form to the patient. The patient is responsible for securing this form and for charges made for its completion.*

Physician signature	Date *MM/DD/YYYY*

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