MCA TRUSTS
HEALTH CARE & RETIREMENT

Allegiance℠
a Cigna Company

APPLICATION FOR SHORT-TERM DISABILITY BENEFITS

PART A – TO BE COMPLETED BY EMPLOYER

1. Policy Number _____
2. Employer (Company) Name _____
3. Employer Tax ID # _____
4. Employer Address _____
   (Street Address)
   _____
   (City) (State) (Zip) (Phone)
5. Employee's Name _____ S.S. # _____
6. Employee's Date of Hire _____
7. Last date employee worked _____
8. Reason for stopping work _____
9. Occupation at time of disability (describe job here including all important duties)
   _____
10. Basic monthly earnings _____ Work Schedule _____
    (days per week) (hours per day)
11. Is this employee eligible for Salary Continuation? Yes No Amount $____ per____ Duration
12. Is this employee eligible for Worker's Compensation? Yes No Amount $_____ per____ Carrier
13. Is this employee eligible for Pension Disability or Disability Retirement? Yes No Amount $_____ per_____
14. Has employee returned to work on a full-time basis yet? Yes No Date _____ (month/day/year)
15. Has employee returned to work on a part-time basis yet? Yes No Date _____ (month/day/year)
16. Has employee worked elsewhere after date of disability? Yes No Where? _____
17. Does the employer withhold Social Security Tax (FICA) from the employee's regular wages? Yes No
18. Is employer considered a private or public enterprise?

Completed By (signature) _____ Date _____

Title _____ Phone _____

PART B – TO BE COMPLETED BY DISABLED EMPLOYEE

1. My full name is _____ S.S. # _____
2. My home address is _____
(Street Address)

_____
(City) (State) (Zip) (Phone)

3. Personal Date: Date of Birth _____ Sex _____
(month/day/year)

Marital Status _____Spouse's Date of Birth _____ Spouse Employed? Yes No
(month/day/year)

3. Occupation _____ List the important duties of your occupation at time of disability: _____
4. I have been unable to work because of this disability since _____
(month/day/year)
5. I returned to work on a part-time basis on _____.
(month/day/year)
I returned to work on a full-time basis on _____.
(month/day/year)
6. I was first treated for this illness or injury on _____.
(month/day/year)
I was first treated for this illness or injury by:
Dr's name _____ Address _____
Dr's name _____ Address _____
7. I first noticed symptoms of this illness or injury on _____. Describe the first symptoms of your illness or describe how and where your accident occurred.

_____
8. Is your accident or illness related to your occupation? Yes No
If "Yes", please explain _____

_____
10. Have you ever had the same or similar condition in the past? Yes No
If "Yes", when? _____
Who treated you? _____ Address _____
Hosp. Name _____ Address_____

Signature of Employee _____ Date _____

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

PART A - TO BE COMPLETED BY PATIENT (INSURED)

Full Name of Patient (please print) _____ D.O.B. _____
Policy # _____ S.S. # _____ Phone _____
Present Address _____
(Street) (City) (State) (Zip)
If Group Insurance, Give Name of Policyholder: _____
(i.e. Employer, Union or Association through whom insured)
Insured's Occupation _____

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I authorize any physician, dentist, medical practitioner, hospital, clinic, pharmacy, or any other provider of health care, any insurance company, government agency, consumer reporting agency, or employer to disclose to the plan's claim processor, or its authorized medical and claims representatives all information and records relating to a diagnosis, treatment, medical history, physical, and mental condition and evaluation or any other information relating to me and any claims on any policy issued. I understand any information obtained will not be released by the plan's claim processor, to any person or organization except its re-insurers, other person or other organizations performing business or legal services in connection with my application or policy, or as may be required by law, or as I may further authorize. A photocopy of this authorization shall be as valid as the original. For the purpose of collecting information in connection with a claim for benefits this authorization remains valid for the term of coverage if the claim is for health insurance benefit, or the duration of the claim if the claim is not for a health insurance benefit. For all other purposes, this authorization remains valid for thirty (30) months from this date. I have a right to receive a copy of this authorization upon request.

Signature of Employee: _____ Date: _____

PART B - TO BE COMPLETED BY ATTENDING PHYSICIAN

1. HISTORY
   - (a) When did symptoms first appear or accident happen? Month____ Day___ Year____
   - (b) Date patient ceased work because of disability? Month____ Day___ Year____
   - (c) Has patient ever had same or similar condition? Yes No
     If "Yes", state when and describe _____
   - (d) Is condition due to injury or sickness arising out of patient's employment?
     [ ] Yes [ ] No [ ] Unknown
   - (e) Names and addresses of other treating physicians:
     _____
     _____

2. PRESENT CONDITION
   - (a) Subjective Symptoms
     _____
   - (b) Objective Findings (including current x-rays, EKG's, laboratory data and any clinical findings)_____
   - (c) Date of last examination Month____ Day____ Year ____

3. DIAGNOSIS (including any complications) _____

4. DATES OF TREATMENT
   - (a) Date of first visit Month_____ Day____ Year_____
   - (b) Date of last visit Month_____ Day____ Year_____
   - (c) Frequency [ ] Weekly [ ] Monthly [ ] Other _____

5. NATURE OF TREATMENT (including name and date of surgery, medications prescribed, and therapy, if any)
   _____

6. PROGRESS

(a) Has patient [ ] Recovered [ ] Improved [ ] Unchanged [ ] Retrogressed

(b) Is patient:
[ ] Ambulatory [ ] House confined [ ] Bed confined [ ] Hospital confined

(c) Has patient been hospital confined? [ ] Yes [ ] No
If "Yes", give name and address of hospital
_____
Confined from _____ through _____.

7. PHYSICAL IMPAIRMENT (*as defined in Federal Dictionary of Occupational Titles)

[ ] Class 1 – no limitation of functional capacity; capable of heavy work* no restrictions (0-10%)
[ ] Class 2 – medium manual activity* (15-30%)
[ ] Class 3 – slight limitation of functional capacity; capable of light work* (35-55%)
[ ] Class 4 – moderate limitation of functional capacity; capable of clerical/admin. (sedentary*) activity (60-70%)
[ ] Class 5 – severe limitation of functional capacity; incapable of minimum (sedentary*) activity (75-100%)

Remarks:
_____

8. PROGNOSIS

(a) Is patient NOW totally disabled and unable to perform patient's job
[ ] Yes [ ] No
If "Yes", when do you expect patient will recover sufficiently to perform patient's job?
[ ] 1 month [ ] 1-3 months [ ] 3-6 months [ ] Never
When did the disability begin? _____

(b) Is patient NOW totally disabled and unable to perform any other work?
[ ] Yes [ ] No
If "Yes", when do you expect patient will recover sufficiently to perform another occupation considering education and experience?
[ ] 1 month [ ] 1-3 months [ ] 3-6 months [ ] Never

9. REHABILITATION

	Patient's Job	Any Other Work
(a) Is patient a suitable candidate for further rehabilitation services? (i.e. cardiopulmonary program, speech therapy, etc.)	[ ] Yes [ ] No	[ ] Yes [ ] No
(b) When could trial employment commence?	_____ (month/day/year) [ ] Full-Time [ ] Part-Time	_____ (month/day/year) [ ] Full-Time [ ] Part-Time
(c) Would vocational counseling and/or retraining be recommended?	[ ] Yes [ ] No	

REMARKS:
_____
_____
_____

I authorize the hospital in which confinement took place to furnish the plan's claim processor full information and disclose all facts concerning the physical condition of the above named patient. A photocopy of this authorization shall be considered as effective and valid as the original.

Name of Attending Physician (print) _____ Degree _____
Street Address _____
City _____ State _____ Zip _____ Telephone_____
Signature X _____ Date _____

When fully completed, mail to MCA Trust Office, P.O. Box 30177, Billings, MT 59107

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