

CDCS HEALTH CLAIMS INC.

Disability Notification Form

TO BE COMPLETED BY Employer

Third Party Administrator

Company & Group policy Number   
Name of Claimant and Cert #

First Day of Absence  Approved Date  Complete After Approved

Type of Claim STD  LTD  Waive Premium Effective Date

Reason for Absence (STD) Accident  Illness  Hospitalization   
(more than 24 hrs)

TO BE COMPLETED BY THIRD PARTY ADMINISTRATOR

Underwriter   
Policy Number

Confirm if employee is eligible for disability benefit  yes  no

STD Waiting Period to apply  days (based on reason for absence above)  
Benefit payment period  weeks

Insured Benefit  per week Taxable  yes  no

LTD Waiting Period to apply  days  
Own Occupation period  years  
Benefit payment period  1 year, 2 years or to 65

Insured Benefit  per month Taxable  yes  no

Employee Cert no.  Sex

Coverage over the NEM for either benefit  If 'yes', give details below and fax Declaration of Insurability form to

Are premiums paid up to date?  If 'no', explain below

Notes

Date of Hire:	<input type="text"/>
Date of Eligibility:	<input type="text"/>
Date EE Joined the Plan:	<input type="text"/>

Completed by  Date

Telephone number  E-mail

If you have any questions regarding this form, please contact CDCS HEALTH CLAIMS INC. at  
Toll Free: 1.800.265.2327