

Employee Name: _____
Employee's SSN: _____

Re: Disability

If you are disabled, we must have proof of your disability in order for our health coverage to continue. Please have the statement below completed by your attending physician.

The completed form should be mailed or faxed to the health care company administering your benefits. The mailing addresses and fax numbers are:

United Healthcare
P. O. Box 5500
Kingston, NY 12402-5500
Fax No. 845.382.6699

Aetna
P. O. Box 981106
El Paso, TX 79998-1106
Fax No. 859.455.8650

Highmark
P. O. Box 890381
Camp Hill, PA 17089-0381
Fax No. 304.424.3180

IF THIS PROOF OF DISAIBILITY IS NOT RECEIVED, LYOUR COVERAGE WILL TERMINATE.

If you are unsure who your health care company is, please call United Healthcare at 800.842.9905.

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To Be Completed By Attending Physician

I certify that \_\_\_\_\_ has been disabled from performing his/her regular occupation from \_\_\_\_\_ (date) to \_\_\_\_\_ (date) due to the following condition(s):

\_\_\_\_\_  
\_\_\_\_\_

Is the employee permanently disabled from his/her regular occupation?  
YES NO (Please circle one)

If no, please give us an estimated return to work date \_\_\_\_\_, or the date of his/her next appointment with you \_\_\_\_\_.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date