first CONCORD
Benefits Group

www.firstconcord.com
P.O. Box 67220
Lincoln, NE 68506
Phone: 402-423-4454
Fax: 402-423-4549

Disability Report

Form must be received directly from physician's office – do not give to insured to return

EMPLOYEE SECTION:

Employee Name _____ Social Security # _____

Address _____

Employer _____ Occupation _____

Were you employed full time when the loss occurred? ○ Yes ○ No

Will a claim be filed with Workmen's Compensation carrier? ○ Yes ◉ No

When were you disabled from work? 03/19/19

When do you expect to return to work? 03/29/19

I hereby certify the above statements are true and correct.

_____ 03/03/19

Employee Signature Date

EMPLOYER SECTION:

Date last worked: _____ Date returned to work: _____

How many hours per week did employee regularly work prior to this loss: _____

Was the employee a full time employee? ○ Yes ○ No

Was this due to any type of Worker's Compensation injury? ○ Yes ○ No

Has a claim been filled for the loss? ○ Yes ○ No

_____ _____

Employer Representative Signature Date

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PHYSICIAN SECTION:

Diagnosis:

_____

_____

_____

Is diagnosis due to injury or illness arising out of person's employment? ○ Yes ○ No

○ Patient was totally disabled from _____ and estimated to remain disabled until _____

○ Patient is released to return to work on _____

What potential change would alter your estimated date of return for the employee?

_____

_____

_____ _____
Physician's Signature Date

_____ _____
Physician's Name (please print or type) Telephone Number

_____
Address

_____ _____
Employer Federal ID#: Individual Practitioner Social Security

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