

Short Term Disability Application Packet

The following forms must be completed, signed and returned to Northern New England Benefit Trust *before* Short Term Disability Benefits can be paid:

1. **Claim and Short Term Disability Status Form**
2. **Physician's Statement (must be completed by an MD)**
3. **Weekly Disability Income Benefit – Memorandum of Understanding**
4. **Patient's Authorization to Release Information**

IN ORDER TO PROCESS A CLAIM YOU MUST ENCLOSE:

ONE CURRENT EMPLOYEE CHECK STUB

F.M.L.A. (Family Medical Leave Act) papers **MUST** be filed with your employer in a timely manner and a copy sent to NNEBT for your disability file. Failure to do so will result in non-payment after four weeks.

The following form must be completed and returned to Northern New England Benefit Trust *after* you return to work:

1. **Return to Work Notice**

Note: Costs incurred for requesting additional medical documentation from your physician will not be the responsibility of NNEBT.

Please be advised, disability income received will be reported by your employer on your W-2 Wage and Tax Statement at the end of the year.

Claim and Short Term Disability Status Form

Instructions:

**Employee must answer all questions, sign and date Employee Statement.
All forms must be returned to process a claim. Mail original forms to:
NNEBT, Attn: Lori Bissanti, P.O. Box 4604, Manchester, NH 03108.**

Employee Statement

Name of Employee: _____ Job Title: _____

Employee's Address: _____ City: _____ State: _____ Zip: _____

Employee's Phone Number: _____

Date of Birth: ____/____/____ Sex: Male[] Female[] Social Security Number: _____
mm day year

Employer: _____ Employer's Phone Number: _____

Employer's Address: _____ City _____ State _____ Zip _____

Gross Weekly Wage (average): \$ _____ *****Must enclose one current check stub*****

Do you have another full or part-time employer? Yes[] No[] If yes, please provide other employer information below

Status: Full Time[] Part Time[] Not Applicable[]

Other Employer: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Gross Weekly Wage (average): \$ _____ *****Must enclose one current check stub*****

When did the accident happen? ____/____/____ **OR** When did the illness begin? ____/____/____
mm day year mm day year

Briefly Describe Injury or Illness: _____

How and where did the injury occur (if applicable): _____

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Date you last worked: ____/____/____
mm day year

Date your disability began: ____/____/____
mm day year

Date you returned to work: ____/____/____
mm day year

If not yet back to work please provide the date that you will most likely return to work: ____/____/____
mm day year

Is this condition related to employment? Yes[] No[] If yes, please provide Workman's Comp Carrier Information

Carrier: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Are you currently or will you be receiving wage-replacement from any other insurer? Yes[] No[]

If Yes, name of insurer:

Contact Person: _____ Phone: _____

Are you seeking legal representation? Yes[] No[] If Yes, please provide:

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

List all treating physicians:

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Did you seek treatment at a hospital emergency room? Yes[] No[]

If Yes, When: ____/____/____
mm day year

Where: _____

Please attach any hospital discharge papers or any physician's notes relative to this claim.

I certify that the above information is true and I am totally disabled, unable to perform my job or any other job. I also authorize the release of any medical information necessary to process this claim.

Employee Signature: _____ Date: ____/____/____
mm day year

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P.O. Box 4604 • 51 Goffstown Road • Manchester, NH 03108

(603) 669-4771 • Fax (603) 666-4477

www.nnebft.org



Disability Status Form

Physician's Statement

Instructions: Physician must be an MD to complete this form.

Patient's Name: _____

Is this condition work related? Yes[] No[]

Diagnosis and Diagnosis Code: _____

Date of first treatment: ____/____/____ Date of most recent treatment: ____/____/____
mm day year mm day year

Date Patient was unable to perform regular job duties: ____/____/____
mm day year

Date of delivery (Re: short term disability for pregnancy): ____/____/____
mm day year

Assessment:

Describe the patient's current physical and mental limitation and work activity restrictions: _____

For how long will the described limitations impair the patient? _____

Describe current treatment: _____

Will the patient require surgery? Yes[] No[] If Yes, date of surgery: ____/____/____
mm day year

Prognosis:

When do you expect a fundamental or marked change in the patient's condition?

When do you anticipate the patient can return to work? _____

Date of next follow up visit: ____/____/____
mm day year

Physician's Name (please Print): _____ Phone: _____

Physician's Signature: _____ Date: ____/____/____
mm day year

Address: _____ City: _____ State: _____ Zip: _____

PLEASE COMPLETE REVERSE SIDE

Return Signed Original to Northern New England Benefit Trust – Employee, and Physician Should Retain a Copy

