

DISABILITY CLAIM FORM

**NORTH EAST FLORIDA
EDUCATIONAL CONSORTIUM**
FRINGE BENEFIT COORDINATORS
1239 NW 10TH Ave
Gainesville, FL 32601
(352) 377-1239 Fax (352) 372-9805
WWW.FBC-INC.COM



Mail claims to:
Fringe Benefit Coordinators
P O BOX 5249
Gainesville, FL 32627-5249

PART 1 EMPLOYEE STATEMENT PLEASE REFER TO INSTRUCTIONS BELOW

EMPLOYEE NAME			SOCIAL SECURITY #		NAME OF DISTRICT	
EMPLOYEE MAILING ADDRESS			EMPLOYEE BIRTH DATE	OCCUPATION		GROUP NUMBER NEF _____
CITY	STATE	ZIP	PHONE NO.	EMAIL ADDRESS (OPT)		NAME OF SCHOOL
IS DISABILITY DUE TO <input type="checkbox"/> ACCIDENT <input type="checkbox"/> SICKNESS <input type="checkbox"/> PREGNANCY			IS CONDITION WORK RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DESCRIBE THE INJURY INCURRED (WHAT, WHERE, HOW) OR THE NATURE AND DETAILS OF THE SICKNESS AND WHEN IT BEGAN:						
DATE OF ACCIDENT OR SICKNESS :			LAST DATE WORKED:		PREVIOUSLY TREATED FOR THIS INJURY OR ILLNESS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
HAVE YOU RETURNED TO WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO			IF YES, WHAT DATE?		<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME	

EMPLOYEE MUST SIGN AND DATE BELOW

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any insurance company, prepayment organization, third party payor, employer hospital or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits for service. I hereby certify the information provided is correct and true to the best of my knowledge.

X _____ Date _____
EMPLOYEE SIGNATURE

PART 2 TO BE COMPLETED BY PHYSICIAN

DOCTOR'S NAME & DEGREE			DOCTOR'S SPECIALTY			
ADDRESS			CITY		STATE	ZIP
PHONE NUMBER		DATE OF FIRST CONSULTATION FOR THIS CONDITION?			ICD-9:	
IS PATIENT STILL UNDER YOUR CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO			PATIENT WAS UNABLE TO WORK FROM		THROUGH	
IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK:					HOURS PER WEEK:	
PHYSICIANS SIGNATURE				DATE		

HOSPITAL INCOME

HOSPITAL NAME			HOSPITAL PHONE NUMBER			
ADDRESS			CITY		STATE	ZIP
DATES OF CONFINEMENT		FROM	TO		PROOF OF CONFINEMENT ATTACHED? <input type="checkbox"/> YES <input type="checkbox"/> NO	

PROCEDURE FOR FILING A CLAIM

1. Complete and sign the "Employee Statement" section of the form (Part #1).
2. Have your doctor complete PART 2 for each claim.
3. Take completed form to the HR office of your employer
4. For Hospital Income claim, please complete Hospital name and address.
5. Attach copy of hospital bill showing dates of confinement