Form last received: _____ Next form due: _____

Short-Term Disability Plan
FOLLOW-UP FORM
FOR EMPLOYEE TO COMPLETE

Employee Name:	Date of Birth:	"C" Number:
Home Address:	City:	Zip Code:
Home Phone:	Department:	Work Phone:

NOTICE TO EMPLOYEE

- **All claim forms MUST be submitted to Benefits Administration, not Human Resources. If Benefits Administration does not receive your claim form, your STD payment will not be processed.**
- **Continuing claim forms MUST be submitted to Benefits Administration every four (4) weeks during disability and MUST be completed by your physician.**

Employee Signature: _____ Date: _____

ATTENDING PHYSICIAN'S STATEMENT

PROGRESS	(a) Patient has: ❑ Recovered ❑ Improved ❑ Stabilized ❑ Retrogressed (b) Patient is: ❑ Ambulatory ❑ House confined ❑ Bed confined ❑ Hospital confined (c) If hospital confined, name and address of hospital: _____ _____ (d) Confined from _____ through _____
PROGNOSIS	(a) What is the patient's prognosis? _____ _____ (b) When do you feel the patient's maximum medical improvement will be reached? ❑ 1 Month ❑ 1 - 3 Months ❑ 3 -6 Months (c) Estimated date patient will return to work: Month _____ Day _____ 20_____
REMARKS	_____ Print attending physician's name: _____ Specialty: _____ Phone: _____ Address: _____ Signature: _____ Date: _____

Submit completed form to Benefits Administration.

(Interoffice)
Benefits Administration
Attn: Illene Diez
100 Gables One Tower
LC: 2902

OR (US Mail)
Benefits Administration
Attn: Illene Diez
PO Box 248106
Coral Gables, FL 33124-2902

OR (Fax)
Benefits Administration
Attn: Illene Diez
305-284-4568