



DISABILITY CONTINUATION CLAIM FORM

Professional Benefit Administrators, Inc.

Send all claims to:
Professional Benefit Administrators, Inc.
P. O. Box 4687
Oak Brook, IL 60522-4687
800-435-5694
Fax: 630-286-4611

INSTRUCTIONS FOR COMPLETING THE CLAIM FORM

- Part A must be completed by the employee.
- Part B must be completed by your physician.
- Return the completed form to the Employee or Employer

Part A - Employee Information

Employer name:		Group#:
Employee name:	Date of birth:	ID #:
Home Address:		Phone:

Part B - Attending Physician Continuation Statement

Most current date of treatment:	Continued disability through date:	Date released to light duty or part time: From: Through:	Date patient able to return to work:
Diagnosis of sickness or injury (describe complications, if any):			
Date of services:		Next scheduled date of treatment:	
Is patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, give discharge date:			
Is patient able to perform work of any kind? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe:			
Date:	Physicians Name (please print)	Degree	Individual Practitioner's SS#: Other Employer ID #'s: (must be furnished under authority of law)
Physician Signature		Phone	
Street Address	City or Town	State or Province	Zip Code