Short Term Disability
Supplementary Claim Report

GE Financial Assurance
Employer Services Group

GE Group Life Assurance Company
100 Bright Meadow Boulevard
PO Box 1955
Enfield, CT 06083-1955

Form must be completed in full at no expense to GE Group Life Assurance Company.

Employee Statement

Name of Employer | Group Policy Number

Name of Employee (Last, First, M.I.) - Please Print | Social Security Number / / | Telephone Number ( )

Address of Employee (No. and Street, City, State, Zip Code)

Are you now receiving or have you filed for: Social Security Retirement or Social Security Disability Benefits? ☐ Yes ☐ No
Workers' Compensation Benefits? ☐ Yes ☐ No If yes, amount $______________ If yes, amount $_________________ Date of Award ______________________

Are you able to work for this or any other employer? (If "yes", give date returned to work)
☐ Yes ☐ No ☐ Full-Time ______________ ☐ Part-Time _______________

If still disabled, give date you expect to return to work for this or any other employer.
☐ Full-Time ____________________ ☐ Part-Time ______________________

Signature of Employee | Date

Attending Physician's Supplementary Statement

Name of Patient (Last, First, M.I.) - Please Print | Date of Birth

Nature of Sickness or Injury (Describe complications, if any)

Nature of Treatment (Including surgery and medications prescribed) Provide prognosis and course of treatment specifically since last update.

For Maternity Claims (Describe complications, if any)

Date of Delivery ________________________ Type of Delivery ☐ Normal ☐ Cesarean

Give Dates of Treatment (Office) | Date of Next Appointment

(Hospital)
From ________________________ To _______________________ | Name and Address of Hospital

If patient has been referred to another physician, please provide name and address.
☐ Yes ☐ No

Is the patient competent to endorse checks and direct the use of the proceeds thereof?
☐ Yes ☐ No

The patient should be able to work on: or in about (Check one)
☐ Full-time Date _____________________ ☐ 1 Month ☐ 1-3 Months ☐ 3-6 Months ☐ Other ____
☐ Part-time Date _____________________ ☐ 1 Month ☐ 1-3 Months ☐ 3-6 Months ☐ Other ____

Have you discharged patient? (If "yes", give date)
☐ Yes ☐ No

Has disability terminated? (If "yes", give date)
☐ Yes ☐ No

Remarks

Name of Attending Physician - Please Print | Tax Identification Number

Signature | Date Signed

Address (No. and Street, City, State, Zip Code) | Telephone Number

State law, in some states, requires the following statement: A person commits a fraudulent insurance act, which is a crime, if he or she knowingly and with intent to defraud any insurance company or other person, either: (1) Files a statement of Claim that contains any materially false information; or (2) Conceals for the purpose of misleading, information about any fact that is material to a claim.