



E.C. Church Benefits Corporation
 100 W. Park Ave., Myerstown, PA 17067
 (717)866-7581

DISABILITY CLAIM FORM

IMPORTANT: This form should be completed by the claimant and his physician.
 PLEASE PRINT LEGIBLY.

Full Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Present Position: _____ Location: _____

Date Accident/Sickness began: _____ Nature of Accident/Sickness: _____

Is condition due to injury/sickness resulting from employment? Yes No

If yes, please explain: _____

If sickness, when were the symptoms first noticed? _____

Has this disease caused previous trouble? Yes No

If yes, please explain when _____

If injured, how or where did the accident occur? _____

Name/Address of Physician: _____

Date first treated: _____ Have you been confined to the hospital? Yes No

If Yes, Name/Address of Hospital: _____

On what date did you or do you expect to resume light work? _____

On what date did you or do you expect to resume your normal duties? _____

Have you or do you intend to file a claim under Workers' Compensation? _____ If yes, date: _____

Have you or do you intend to file this claim under any other insurance or retirement plans? _____

Name of Company	Monthly Indemnity	Type of Plan
_____	_____	_____
_____	_____	_____

SIGNATURE _____ DATE _____
 (Claimant)

SIGNATURE _____ DATE _____
 (Church Official)

SIGNATURE _____ DATE _____
 (Conference Minister)

Attending Physician Supplemental Statement to be completed and signed on Page 2

ATTENDING PHYSICIAN'S SUPPLEMENTAL STATEMENT

Patient's Name: _____

Diagnosis and Concurrent Conditions: _____

Date of First Treatment/Visit/Consultation: _____

Date of Most Recent Treatment/Visit/Consultation: _____

Frequency of Patient Visits: _____

The patient has been continually disabled and unable to work from _____ through _____. (Please insert applicable dates)

If still disabled, when should the patient be able to return to work? _____

Please explain: _____

Physician's Name/ Address/ Phone: _____

Signed: _____ Date: _____