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Aetna

Sick Leave/Disability Claim Application Employee Statement

If you have any questions, please call (888) 774-1371. Fax or mail this completed form to:

Aetna Life Insurance Company
Managed Disability – Tampa
P.O. Box 14553
Lexington, KY 40512-4553
Fax: 877-848-9047
Phone: 888-774-1371

Instructions:

- Complete this form when your disability is expected to last for more than five (5) calendar days.
- Ask your physician to complete the Attending Physician's Statement.

1. Employee Statement

Employer's Name	Control Number	Exchange Number
Army and Air Force Exchange Service	**750573**	

Employee's Name	Employee's Home Telephone (including country code access)

Employee's Description Of Condition	Social Security Number

Job Title and Brief Description of Job Duties

☐ Light Labor ☐ Heavy Labor ☐ Clerical/Administrative

Date Last Worked	Was More Than A Half Day Completed? ☐ Yes ☐ No	Anticipated Return To Work Date

Date Hired	First Day Missed	Usual Work Schedule

Is Claim Related To Employment? ☐ Yes ☐ No	If claim is due to an accident, description of accident.

2. Federal Income Tax Withholding Information

Disability Income payments are reported to the Federal Government and may be included as taxable income. Disability benefits are provided by an Administrative Services contract (ASC); Aetna defaults to a filing of single zero, this amount will vary depending on benefit amount. This amount will automatically be deducted.

If you choose to change that amount, you must complete and mail/fax a W-4 form to the address/fax number above.

(You can obtain a W-4 form from your HR Representative or at www.irs.gov)

3. State Income Tax Withholding Information (if applicable)

If you claim residency in a state that has a law requiring state income tax withholding for disability payments, an additional amount must be withheld from your disability payment.

These states are: Illinois (3%); Virginia (4%); North Carolina (7%).

If you choose to change that amount, you must complete your states required state withholding form. The form must be completed and mailed/faxed number above.

4. Regulation Notice

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature	**Date** *(D/MMM/YYYY)*

Aetna

Attending Physician's Statement

Complete and sign the form using BLUE or BLACK ink.

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Managed Disability - Tampa
P.O. Box 14553
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Fax: 877-848-9047

1. Patient Instructions – The Physician will complete Sections 2 through 7.
The Patient will complete Section 1.
The Patient should also fill in their name at the top of Page 1 and 2

The ***Patient*** is responsible for completing this section, and for **ensuring** that their **Attending Physician completes the remainder of this statement.** The Patient is responsible for paying any fees that may be charged for completion of this form by their physician.

(a) Control Number **750573**

(b) _____
Patient Name (Last, First, Middle Initial) Social Security Number Birth Date (D/MMM/YYYY)

(c) Job Title/Occupation

2. Physician Instructions

The ***Attending Physician*** should **complete the items below**, based upon a **recent examination.** Attach additional documentation as needed.

Please complete form in its entirety and fax to 877-848-9047. Page 2 MUST be completed before faxing.

3. Impairing Diagnosis & Treatment

(a) **For medical reasons, the patient will need to be absent from work due to a disability beginning on** _____ (D/MMM/YYYY) **and ending on** _____ (D/MMM/YYYY) **.**

(b) Primary Diagnosis _____ Primary ICD Code _____
Secondary Diagnosis _____ Secondary ICD Code _____
Other Diagnoses _____ Other ICD Codes _____

(c) Primary Procedure _____ Primary CPT Code _____
Secondary Procedure _____ Secondary CPT Code _____
Other Procedures _____ Other CPT Codes _____

(d) Medication(s)/Dose/Frequency _____

(e) Treatment summary _____

(f) Height _____ Weight _____ B/P _____ Pulse _____ Resp _____ Date Measured (D/MMM/YYYY) _____

(g) Office visit dates: First _____ (D/MMM/YYYY) Last _____ (D/MMM/YYYY) Next _____ (D/MMM/YYYY) Frequency of appointments _____

(h) Was patient recently hospitalized? ☐ No ☐ Yes Date hospitalized: Admit _____ (D/MMM/YYYY) Discharge _____ (D/MMM/YYYY)

(i) Hospital Name/City _____

4. History

(a) Symptoms: _____

(b) Date symptoms first appeared or accident happened ..... D_____ MMM_____ YYYY _____

(c) Is condition due to injury or sickness arising out of patient's employment? ☐ No ☐ Yes ☐ Unknown

5. Abilities/Limitations

(a) **Patient is able to do: Select one: Place remarks in item (d) below, if applicable.**

- ☐ **Heavy work** activity. No limitations of functional capacity.
- ☐ **Medium work** activity. Exerting 20-50 pounds of force occasionally, and/or 10-25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly
- ☐ **Light work** activity. Exerting up to 20 pounds of force occasionally and/or up to 10 pounds of force frequently
- ☐ **Sedentary work** activity – moderate limitation of functional capacity. Exerting up to 10 pounds of force occasionally. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time
- ☐ **No ability to work.** Severe limitation of functional capacity; incapable of minimal activity
- ☐ **Other.** Place remarks in item (d) below.

Patient Name (*Last, First Middle Initial*) **Required**

5. Abilities/Limitations (Continued)

(b) **What medical restrictions/limitations are you placing on patient? (Activities of Daily Living, Driving, Lifting, Pulling, *Pushing, and Amounts, etc.)***

- Date you prescribed restriction on work activities Day _____ Month _____ Year _____
- How long are these restrictions/limitations in effect? _____ Days _____ Weeks _____ Months ☐ No Longer
- Estimated return to work date? _____ (D/MMM/YYYY) modified duty / _____ (D/MMM/YYYY) full duty

(c) **Objective findings that substantiate impairment** *(current laboratory, physical and/or mental status examination, and other testing)*

(d) Other/Comments

6. Physician Information

Attending Physician's Name *(Print)*	Degree	Specialty
Address (No. Street, City, State, Zip Code)	Telephone Number	Fax Number
Signature		**Date** *(D/MMM/YYYY)*

7. Regulation Notice

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