

PROOF OF DISABILITY FORM - POD

We are in receipt of information from the employer indicating the insured employee was unable to work due to a disability. For coverage to continue under your group health policy, the attending physician must complete the below disability statement.

As soon as this statement is completed and returned to us, we will complete the processing of outstanding claims. If we do not receive the statement, no payments can be issued for either the employee and /or eligible dependents.

DISABILITY STATEMENT			
Employee's name	Member SSN# -	Employer: NS	
Date patient first consulted you for this condition?	Is patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	Patient was continuously, totally disabled unable to work From To	Is still disabled, date patient could return to Regular Duties
Diagnosis and Concurrent Conditions			
Attending Physician's Name & Address	Attending Physician's Signature	Date	

Please fax or mail this form to the employer's insurance provider.

UNITED HEALTHCARE

P.O. BOX 5500
Kingston, NY 12401

Fax: 414-921-4667
1-800-842-5252