Insight Benefit Administrators LLC
Phone (877) 827-1414 or (616) 588-5340
PLEASE FAX OR EMAIL ALL CLAIM FORMS TO:
Fax (616) 588-7915 - Email: RA_TPA@insightba.net
3033 Orchard Vista S.E., Suite 312 Grand Rapids, MI 49546

SHORT TERM DISABILITY BENEFITS

INSTRUCTIONS FOR FILING A DISABILITY CLAIM

THIS FORM IS FOR SHORT-TERM DISABILITY BENEFITS ONLY.
TO AVOID DELAY OR RETURN, PLEASE FOLLOW THESE INSTRUCTIONS.

To the Claimant: A. Complete and sign the Claimant section.
B. Have the Attending Physician complete and sign the Attending Physician section.
C. Return the fully completed form to your Employer/Administrator who will submit the form to the claim office.

TO BE COMPLETED BY THE CLAIMANT

Name of Employee (Last Name) (First name) (M.I.)	Date of Birth	Social Security No.	Gender ☐ M ☐ F

Address (Street) (City) (State) (Zip Code)	Telephone No. ( ) -

Date of accident or beginning of sickness	First date you were unable to work	Date you plan to return to work

Was your Disability caused by any of the following: Accident ☐ **Yes** ☐ **No** Auto accident ☐ **Yes** ☐ **No**

Work related injury ☐ **Yes** ☐ **No** If work related has a Workers Compensation claim been filed ☐ **Yes** ☐ **No**

Describe, in your own words, the condition(s) affecting you (if accident, describe circumstances and location of accident).

Please list any hospitals, clinics or physicians that treated you for your illness or injury

Name	Complete Address	Treatment Period

Please give your occupation and describe your job duties in detail. What percentage of your job requires physical labor?

Please list all benefits you are receiving or eligible to receive under any other Group Insurance, Government Plan or Automobile Mandatory No-Fault coverage. Include name, address and telephone number of other Carrier.

Benefit	Address	Gross Weekly Amount	Date began	Paid thru date

THIS IS TO CERTIFY THAT THE FACTS AS INDICATED ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

Signature of Employee: _____ Date Signed: _____

Authorization to Release Information

To all physicians and other health care professionals, and all hospitals and other health care institutions: You are authorized to provide Insight Benefit Administrators LLC information concerning health care advice, treatment or supplies provided to the Patient (including those relating to mental illness or substance abuse, HIV infection, AIDS, or AIDS related complex). This information will be used for the purpose of evaluating and administering claims for benefits. This authorization is valid for the term of coverage for the policy or contract under which a claim has been submitted. I know that I have the right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Signature of Employee: _____ Date Signed: _____

Insight
Benefit Administrators

ACH Deposit for Disability Checks – NECESSARY TO BE COMPLETED FOR CLAIMS PAYMENT

New ☐ Change ☐ Term ☐

Customer Information: *(please print clearly)*

Name:_____
Address:_____
_____
Tel. No.: _____
Email Address:_____

Bank Account Information*:

Financial Institution Name:_____
Name(s) on Account: _____
Routing Number: _____
Account Number: _____

(Please attach a voided check. Deposit slips are not valid)

Type of Account:

(check one) ☐ Checking ☐ Savings

Authorization:

I hereby authorize Insight Benefit Administrators LLC to transfer payment to the financial institution listed above.

Date:_____ **Signed:**_____

Cancellation:

Date:_____ **Signed:** _____

Please EMAIL OR FAX to:

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RA_TPA@Insightba.net

Fax: 616-588-7915
Phone: 616-588-5340
877-827-1414

***Please contact Insight Benefit Administrators immediately if you change financial Institutions**.

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Patient Name:	Diagnosis and concurrent conditions, including ICD-10 code.

Is this condition due to pregnancy? ☐ **Yes** ☐ **No** If "yes" please provide the information below, if applicable.

Approximate date pregnancy commenced	Estimated date of confinement	Date of delivery

Complications, if any

Is the condition due to injury or illness caused by the patient's employment? ☐ **Yes** ☐ **No**	Date symptoms first appeared, or accident happened.	Date patient first consulted you for this condition.

Dates of services – include date of next appointment (if previous form submitted to this payer, you need show only dates since last report)

Has the patient ever had same or similar condition? ☐ **Yes** ☐ **No** If "yes" when and describe.	Patient still under your care for this condition? ☐ **Yes** ☐ **No**

Has the patient been hospital confined? ☐ **Yes** ☐ **No** If "yes" confined from: _____ thru: _____

Name and Address of hospital: _____

Nature of surgical procedure, if any: _____

☐ Inpatient ☐ Outpatient Date performed: _____

Patient was continuously totally disabled – (unable to work). From: Thru:	If still disabled, date patient should be able to return to work.

Reason why this condition prevents patient's return to full-time employment.

Date	Physician's Name (please print)	Signature

Degree	Tax Identification Number	Telephone Number

Street Address City or Town State or Province Zip/Postal Code

TO BE COMPLETED BY THE EMPLOYER

PLEASE CHECK THE APPROPRIATE BOXES REGARDING THE INSURED'S EMPLOYMENT STATUS.

☐ Exempt ☐ Non-Exempt ☐ Salaried ☐ Hourly ☐ Full-time ☐ Part-time

Basic earnings per week	Date of last change in Earnings	Date Hired	Effective date of Insurance

Last date worked Number of hours	Date returned to work	Salary continuance paid thru date

Name of Employer	Division

Address (street) (City) (State) (Zip Code)	Telephone Number ( ) -

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Signature of Authorized Representative:_____Date Signed:_____