MedCost Benefit Services
P O Box 25987 Winston-Salem NC 27114-5987

STATEMENT OF CLAIM
WEEKLY INCOME - PLAN

Instructions: (1) Employee completes Part A (2) Physician completes Part B (3) Employer completes Part C.

PART A Employee information

Employee Name (First, Middle Initial, Last) ____ Male ____ Female Birthdate _ _ Social Security # _ _

Home Address

Reason for Claim: __Illness __Accident

If 'accident' please provide date, place and how it happened below

Date _________ Place ______________________________

Was illness or accident Work-related? ___Yes ___ No

How ______________________________

____

How long were or will you be physically unable to work?

First date of disability _____________ Last day of disability _______________

AUTHORIZATION TO RELEASE INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, Insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, employer or third party administrator having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my dependents and any other non-medical information of me or my dependents to give my employer, third party administrator or its plan supervisor, MedCost Benefit Services, LLC, or its legal representative, any and all such information.

I UNDERSTAND information obtained with the Authorization will be used by MedCost Benefits Services, LLC, to determine eligibility for coverage and eligibility for benefits under an existing plan. Any information obtained will not be released by MedCost Benefit Services, LLC, to any person or organization except to the plan administrator, my employer, third party administrator, reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with the claim, or as may be otherwise lawfully required or as I may further authorize. **I KNOW** that I may request to receive a copy of this Authorization.

I AGREE that a photocopy of this Authorization shall be as valid as the original. **I AGREE** this Authorization shall be valid for two and one half years from the date shown below, or for the duration of this claim, if longer.

Date ______________ Employee's signature ______________________________

PART B Attending Physician's Statement

Nature of sickness/injury (Describe complications, if any)

____

Date and Nature of surgical or obstetrical procedure, if any

____

The patient has been continuously unable to work
From (date): ______________Through (date): _______________

If still disabled, provide the expected date to return to work
____

Have you discharged the patient? ___ Yes on (date)______
___ No

First date of treatment during this disability period?
____

If this claim is due to pregnancy, give estimated delivery date ______________________________

Physician's Name ______________________________ Please Print

Physician's signature ______________________________

Address ______________________________ Street

Date___________________

____
City State Zip

PART C Employer's Statement

NOTE: YOUR CLAIM CANNOT BE PROCESSED UNTIL YOUR EMPLOYER COMPLETES THIS SECTION

Employee's Name ______________________________ Status: ___Active ___Retired ___Lay-off ___Leave of Absence

Last day Employee worked ________ Has the Employee returned to work as of the date this claim was filed? ___No ___Yes, on (Date)__________________

Provide weekly salary: $________________ Were injuries or sickness in any way connected with the Employee's occupation? ___No ___Yes

Signature of Employer's Representative: ______________________________ Date: ________________________