

**General Dynamics**  
**Short Term Disability (STD)**

**Customer Service 1-888-777-7039**

Employee Name		Employee ID		Social Security Number		Date of Birth	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Address			City		State	Zip Code
Employee Home Phone #	Business Unit	Supervisor Name		Employee Work Number #			
Location Name		Location Address		Current Occupation			
Date of Hire	Union Employee <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Hourly Employee <input type="checkbox"/> Salaried Employee		Last Day at Work		First Day Absent from Work
Date Returned to Work		Is this claim related to an accident?		Salary Annual: Hourly Rate:		Is Absence Work Related? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you used disability benefits in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	Admit Date	Discharge Date		
Hospital Name		Hospital Address			Phone #	Fax #	
Physician Name		Physician Address			Phone #	Fax #	

**AUTHORIZATION FOR RELEASE OF  
PROTECTED HEALTH INFORMATION  
(DISABILITY BENEFITS)**

I, the undersigned, hereby authorize representatives of Sedgwick CMS or one of its affiliated companies ("Sedgwick CMS") and any independent claims administrators and consulting health professionals and utilization review organizations whom Sedgwick has contracted or its representative to obtain from any health care provider or related party any relevant information concerning advice, care, or treatment provided to me or other information relating to my claim for disability benefits. This information will only be used to evaluate claims for benefits.

My health information is to be made available, upon request, to Sedgwick CMS or its representative. Sedgwick CMS may release my health information to any person or facility that coordinates my Long Term Disability Benefits (Aetna), or coordinates my health insurance benefits, or to the Social Security Administration or to a social security, vocational rehabilitation vendor, or to compliance investigatory personnel to the extent all or any of such health information is considered by Sedgwick CMS or its representative to be relevant to the determination of my claim. I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose this information. This information will only be used to evaluate claims for benefits.

I further understand that I have the right to revoke this authorization at any time by submitting a revocation request in writing to the attention of the IDM Manager, Sedgwick CMS, PO Box 804417, Chicago, Illinois 60680-8044, Fax number 1-312-347-6800. This revocation will be effective after receipt, review and processing on a prospective basis only. I understand that my revocation of this authorization shall terminate my right to receive prospectively additional disability benefits, but shall not affect my right to disability benefits to which I was entitled during the period this authorization was in effect. Moreover, I understand that the revocation of this authorization may result in denial of any pending request for a reasonable job accommodation, and/or discontinuance of a job accommodation that is already in place.

**Absent my revocation, this authorization shall remain valid for the duration of my claim for short-term disability.**

I understand that I have a right to request and receive a copy of this authorization. A photocopy of this authorization shall be valid and is to be accepted with the same effect as the original.

Printed Name of Employee: \_\_\_\_\_

Signature of Employee or Personal Representative: \_\_\_\_\_ Date: \_\_\_\_\_

If a personal representative executes this form, that representative warrants that he or she has the authority to act on behalf of the employee in signing this form and that the basis for this authority is as

follows: \_\_\_\_\_

(Attach documentation that evidences the authority to act as a personal representative.)

Fax: 1-866-261-5795

# ATTENDING PHYSICIAN STATEMENT

The patient is responsible for any expense incurred for completion of this form

**Note: Sedgwick may request additional statements as necessary**

Name
Social Security Number

Patient's Name		Patient's Birth date (MM/DD/YY)	
Date of Illness (first symptom) or injury(incident) or pregnancy(LMP)		Date first seen and treated for this condition	If patient has had similar illness or injury ,give dates
Dates of Disability MM DD YYYY      MM DD YYYY From / / through / /		Date of Hospitalization (If applicable) MM DD YYYY      MM DD YYYY From / / through / /	
Date patient able to return to work (if unknown, give estimate) MM/DD/YYYY			

Diagnosis of nature of illness or injury (Please indicate primary and secondary)

- 1.
- 2.
3. MM DD YYYY
4. If disability due to pregnancy, the expected delivery date is / /

List current medications and dosages

**Procedures and/or Medical Services related to disability**

Date of Service MM DD YYYY	Description of Service	Type of Service	Diagnosis Code

**Limitations**

- (a) What are the present capabilities? \_\_\_\_\_
- (b) What are the present limitations (physical/mental)? \_\_\_\_\_
- (c) What restrictions are placed on patient? \_\_\_\_\_

(d) Name of referring physician \_\_\_\_\_ Date of next visit MM DD YYYY / /

**Physical Impairment – As defined in Federal Dictionary of Occupational Titles**

- Class 1 – No limitations of functional capacity; capable of heavy work \* No restrictions (0-10%)
- Class 2 – Medium manual activity \* (13-30%)
- Class 3 – Slight limitation of functional capacity; capable of light work \* (35-50%)
- Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary\*) activity (60-70%)
- Class 5 – Severe limitations of functional capacity; incapable of minimal (sedentary\*) activity (75-100%)
- Remarks: \_\_\_\_\_

**Mental/Nervous Impairment (if applicable)**

What stress and problems in interpersonal relations has claimant had on job:

- Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations)
- Class 2 – Patient is able to function in most stress situations and engage in interpersonal relations (slight limitation)
- Class 3 – Patient is able to engage in stress situations and engage in only limited interpersonal relations (moderate limitation)
- Class 4 – Patient is unable to engage in stress situations and engage in interpersonal relations (marked limitation)
- Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitation)
- Remarks: \_\_\_\_\_

Physician Signature	Date (MM/DD/YYYY)
Physician Name & Address (include zip code)	Telephone Number:
	Fax Number