

# The Manhattan Insurance Company

## Disability Claim Form

Any person who knowingly and with intent to defraud 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

### TO BE COMPLETED BY THE INSURED:

Policy No. \_\_\_\_\_

#### Section I

1. Name of Insured \_\_\_\_\_ Date of Birth \_\_\_\_\_ S.S. # \_\_\_\_\_
2. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # ( ) \_\_\_\_\_
3. Name of Employer \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
4. Occupation \_\_\_\_\_ Duties \_\_\_\_\_
5. Date sickness began or accident occurred \_\_\_\_\_ Date you last worked \_\_\_\_\_
6. Nature of sickness or injury \_\_\_\_\_
7. Have you had the same or similar sickness before? \_\_\_\_\_ If yes, explain \_\_\_\_\_
8. If injured, how, and where did the accident occur? \_\_\_\_\_
9. First treating physician: Full name \_\_\_\_\_ Address \_\_\_\_\_ Date \_\_\_\_\_
10. Date disability began: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ A.M. \_\_\_\_\_ P.M. \_\_\_\_\_
11. On what date did you (or do you) expect to resume any part of your work? \_\_\_\_\_

#### AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person, that has any records or knowledge of me or my health, to give The Manhattan Insurance Company, or its representatives, any such information.

A photographic copy of this authorization shall be as valid as the original.

APPROVED BY: \_\_\_\_\_

DATED \_\_\_\_\_

SIGNED \_\_\_\_\_

Attending Physician

Claimant's Signature

### TO BE COMPLETED BY ATTENDING PHYSICIAN: FAILURE TO PROVIDE ALL INFORMATION REQUIRED BELOW MAY DELAY PAYMENT

#### Section II

1. Name of Patient \_\_\_\_\_ Age \_\_\_\_\_
  2. How long have you been Insured's physician \_\_\_\_\_
  3. Nature of sickness or injury, describe complications, if any \_\_\_\_\_
  4. When did the patient first consult you for this condition? \_\_\_\_\_
  5. List all treatment for this condition \_\_\_\_\_
  6. If patient hospitalized, give name and address of hospital \_\_\_\_\_  
Date admitted \_\_\_\_\_
  7. Was surgery performed? \_\_\_\_\_ If so, procedure and date performed \_\_\_\_\_
  8. Has the claimant had the same or similar illness before? If yes, when? \_\_\_\_\_
  9. How Long Was Or Will Patient Be Continuously Totally Disabled? FROM \_\_\_\_\_ TO \_\_\_\_\_
  10. How Long Was Or Will Patient Be Partially Disabled? FROM \_\_\_\_\_ TO \_\_\_\_\_
  11. Was the patient referred to another doctor? \_\_\_\_\_ if so, whom? \_\_\_\_\_
  12. Confining Date \_\_\_\_\_ Thru \_\_\_\_\_ Non Confining Date \_\_\_\_\_ Thru \_\_\_\_\_
- Typewritten name of Physician \_\_\_\_\_ Address \_\_\_\_\_ Degree \_\_\_\_\_
- Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone No. \_\_\_\_\_

### TO BE COMPLETED BY THE EMPLOYER:

#### Section III

1. Employer Name \_\_\_\_\_ Address \_\_\_\_\_ Zip \_\_\_\_\_
  2. Employer's Phone # ( ) \_\_\_\_\_ Workmen's Comp Claim Filed ? \_\_\_\_\_
  3. Name of Compensation carrier \_\_\_\_\_
  4. Between what dates did employee give up all duties: TOTAL DISABILITY FROM \_\_\_\_\_ TO \_\_\_\_\_
- Date \_\_\_\_\_ Title \_\_\_\_\_ Signature \_\_\_\_\_

Form No. 701-NY

**No faxed claims accepted**

**COMPLETE AND RETURN  
THIS FORM PROMPTLY**

**The Manhattan Insurance Company**  
5 Waterside Crossing, Third Floor  
Windsor, CT 06095

