Employee Name: _____

Employee's SSN: _____

Re: Disability

If you are disabled, we must have proof of your disability in order for your health coverage to continue. Please have the statement below completed by your attending physician.

The completed form should be mailed or faxed to the health care company administering your benefits. The mailing addresses and fax numbers are:

UnitedHealthcare
P.O. Box 5500
Kingston, NY 12402-5500
Fax #: (845) 382-6699

Aetna
P.O. Box 981106
El Paso, TX 79998-1106
Fax #: (859) 455-8650

Highmark
P.O. Box 890381
Camp Hill, PA 17089-0381
Fax #: (304) 424-3180

IF THIS PROOF OF DISABILITY IS NOT RECEIVED, YOUR COVERAGE WILL TERMINATE.

If you are unsure who your health care company is, please call UnitedHealthcare at (800) 842-9905.

To Be Completed By Attending Physician

I certify that _____ has been disabled from performing his/her regular
(Name)
occupation from _____ to _____
(Date) (Date)
due to the following condition(s):

_____

_____

Is the employee permanently disabled from his/her regular occupation? YES NO
(Please circle one)

If no, please give us an estimated return to work date _____, or the date of his/her next appointment with you _____,

_____
Physician's Signature Date