

Subscriber ID _____

Re: Disability Letter

We are in receipt of information from your employer indicating that you have stopped working because you are disabled. In order for your health coverage to continue, we must have the proof of disability 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 address and fax number are:

UnitedHealthcare
PO Box 30985
Salt Lake City UT, 84130-0985
Fax# (845) 382 6699

Aetna US Healthcare
PO Box 7064
Dover DE 19903-1512
Fax# (859) 455 8650

Highmark BC/BS
PO Box 890381
Camphill, PA 17089
Fax# (304) 424-3180

IF THIS PROOF OF DISABILITY IS NOT RECEIVED YOUR COVERAGE WILL BE TERMINATED.

If you are unsure who your Health Care Company is, please check your ID card or call UnitedHealthcare at (800) 842 5252

TO BE COMPLETED BY ATTENDING PHYSICIAN:

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

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

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

Physicians Signature: _____ Date: _____