**CASE #:** ____________

UNITED ADMINISTRATIVE SERVICES

1120 S. BASCOM AVENUE
SAN JOSE, CALIFORNIA 95128-[illegible]

PHONE (408) 288-4400
FAX (408) 288-4439

# DISABILITY PROGRESS REPORT

## CLAIMANT'S STATEMENT

To Be Completed And Returned On Recovery Or AS SOON AS POSSIBLE If Still Disabled.

__√__ If Checked, Your Physician Must Complete Reverse Portion Of This Form

| | |
|---|---|
| The Company You worked for: | Your Name |
| Are you still unable to work because of your medical condition?<br>(A) If No, date you recovered. | Yes ☐ No ☐ |
| Could you perform another occupation? If Yes, please elaborate below. | Yes ☐ No ☐ |
| Give dates of treatment since last report. | Office:<br>Home:<br>Hospital: |
| Have you been confined to a hospital since last report?<br>(A) If Yes, give name and address of hospital. | Yes ☐ No ☐<br><br>Admitted ____________, 20____ Discharged ____________, 20____ |
| Are you receiving Disability income benefits from any source other than this Plan, or compensation of any kind?<br><br>If Yes, please indicate flame and address of Payor: | Yes ☐ No ☐ |
| Remarks: | |

### AUTHORIZATION FOR USE IN CLAIMING BENEFITS

To all physicians and other medical professionals, hospitals and other medical care institutions, and to insurers, medical or hospital service and prepaid health plans, family members, employers (past or present) and group policyholders or plan administrators.

You are authorized to provide United Administrative Services, its representatives, or my Employer with information concerning medical care, advice, treatment or supplies provided, and any employment or financial related information. This authorization includes (but is not limited to) psychiatric, drug, or alcohol abuse history or treatment. This information will be used for the purpose of evaluation and administering claims for benefits.

I agree that a photocopy shall be as valid as the original. I know that I have a right to request a copy of this authorization. I understand that this authorization may be revoked by written notice, but this will not apply to information already released. If not revoked, this authorization will be valid while the claim is pending or for one year from the date signed.

______________________________
Signature:

Phone: (____) ____________________ Date: ____________________

Street No.: ____________________ City: ____________________ State: __________ Zip: __________

(If P.O. Box - Also show Street Address)

CASE #: ____________

UNITED ADMINISTRATIVE SERVICES

1120 S. BASCOM AVENUE
SAN JOSE, CALIFORNIA 95128-3590

PHONE (408) 288-4400
FAX (408) 288-4439

# PHYSICIAN'S SUPPLEMENTAL STATEMENT

(To Be Completed And Signed By Attending Physician)

Patient's Name | Age ____________

Nature of sickness or injury. (Describe complications if any)

Describe any other disease or infirmity affecting present condition.

| | |
|---|---|
| Give dates of treatment since ____________ | Office:<br>Home:<br>Hospital: |
| Is patient still under your care for this condition?<br>If discharged, give date. | Yes ☐ No ☐ |
| Please complete if hospitalized. | Hospital City State Zip<br>Date Admitted ____________, 20 ____<br>Date Discharged ____________, 20 ____ |
| Duration of Disability:<br>(A) Is patient now able to work with reasonable continuity?<br>(B) If Yes, when was patient able to go to work?<br>(C) If No, when do you think patient will be able to resume work? | For his regular occupation Yes ☐ No ☐<br>For any occupation Yes ☐ No ☐<br>Mo. ____________ Day ______, 20 ____<br>Approximate Date Mo. ____________ Day ______, 20 ____ |
| What is patient's progress? | Recovered ☐ Improved ☐<br>Unimproved ☐ Retrogressed ☐ |

Remarks

______________________________________________

______________________________________________

______________________________________________

______________________________________________

____________________
Date

Phone (    ) ____________________

____________________
Street Address

____________________
Name Specialty

____________________
Signature

____________________
City or Town State Zip