State Mutual Insurance Company
Box 1404
Rome, GA 30162-1404
Office: 1-855-774-4495
Fax: 1-813-386-4425

Platinum SUPPLEMENTAL INSURANCE

INITIAL DISABILITY CLAIM FORM

PLEASE NOTE: It is important that all questions be answered in full and that this form be returned to the company. Failure to complete all sections may result in a delay in processing this claim.

1. Policy Number: _____
2. Policyholder's Name: _____
3. Patient's Date of Birth _____ / _____ / _____
4. Address: _____
   Street City State Zip
   a. If this is a permanent address change, please check here ☐
5. Phone number (_____) _____ - _____
6. Is this the initial claim for this accident? ☐ Yes ☐ No
7. Date of the injury: _____ / _____ / _____
8. Describe how the injury occurred: _____
   _____
9. First Date of Treatment for this diagnosis: _____ / _____ / _____
10. Was this a motor vehicle accident in which the patient was the driver? ☐ Yes ☐ No
    (If yes, please submit a copy of the MVA report.)

Treatment Facility Name: _____

Address: _____
Street City State Zip

I understand that this information will be used by State Mutual Insurance Company for the purpose of evaluating my claim for insurance benefits. I represent that the answers to the above questions are complete, true and correct to the best of my knowledge and belief. I understand that I or my authorized representative is entitled to receive a copy of this form upon request.

Patient Name	Patient Signature	Date Signed (MM/DD/YYYY)

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INITIAL DISABILITY CLAIM FORM:

EMPLOYER'S STATEMENT

PLEASE NOTE: It is important that all questions be answered in full and that this form be returned to the company. Failure to complete all sections may result in a delay in processing this claim.

1. Policy Number: _____
2. Employee's Name: _____
3. Employee's Date of Birth: _____/_____/_____
4. Employer's Name: _____
5. Employer's Address: _____
   Street City State Zip
6. Employer's Phone Number: (_____) _____-_____
7. Employee's Date of Hire: _____/_____/_____ Employee's Job Title: _____
8. First date of disability: _____/_____/_____
9. Was this disability caused by an incident that occurred while performing the duties of his/her employment? ☐ Yes ☐ No
10. Has the employee returned to work? ☐ Yes ☐ No
    If yes, date returned to work: _____/_____/_____
    If no, expected return to work date: _____/_____/_____
11. If the employee has returned to work is he / she working:
    ☐ Full-Time ☐ Part-Time ☐ Light Duty.
12. Is the person still employed? ☐ Yes ☐ No
    If no, last date of employment: _____/_____/_____

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Employer's Name	Employer's Signature and Title	Date Signed (MM/DD/YYYY)

Platinum Supplemental Insurance
PO Box 1404, Rome, GA 30162
Fax: 813-386-4425

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Platinum SUPPLEMENTAL INSURANCE

INITIAL DISABILITY CLAIM FORM:

PHYSICIAN'S STATEMENT

PLEASE NOTE: It is important that all questions be answered in full and that this form be returned to the company. Failure to complete all sections may result in a delay in processing this claim.

1. Policy Number: _____

2. Patient Name**:** _____

3. Patient Date of Birth: _____

4. Physicians Name: _____

5. Physician Address: _____
   Street City State Zip

6. Physician Phone Number: _____

7. Patient first date of disability: _____

8. Nature of disability: _____

   _____

9. Initial date of treatment for this disability: _____

   Expected return to work date: _____

10. Primary Diagnosis Code: _____ Diagnosis: _____

    Secondary Diagnosis Code: _____ Diagnosis: _____

11. Is the Patient unable to performed Activities of Daily Living: ☐ Yes ☐ No

    If Yes, please list which ADLs the patient is unable to perform: _____

    _____

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_____ _____ _____
Physician's Signature Date Signed (MM/DD/YYYY) Tax ID #

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