

**Section I
APPLICATION FOR SHORT TERM DISABILITY INCOME BENEFITS
EMPLOYER'S STATEMENT**

To Be Completed by the Employer

This claim is for: (Employee's Name)	Social Security Number:	Date of Birth:
Employee's Home Address: (Street, City, State & Zip.)		Date of Hire:

A. Information About the Employer

Name and Address of Division Where Employee Works:

B. Information About the Claim

What was the employee's permanent job on his or her last day at work? (Please attach a copy of the employee's job description.)

Last day employee actually worked	On that day, did the employee work a full day? <input type="checkbox"/> YES <input type="checkbox"/> NO If "No" how many hours were worked? _____
-----------------------------------	--

C. Information About the Physical Aspects of the Employee's Job

Check the items below that relate to the employee's job and complete the information requested. Use these definitions for the frequency of occurrence.

- Not Applicable** means the person does not perform the activity.
- Occasionally** means the person does the activity up to 33% of the time.
- Frequently** means the person does the activity 34% to 66% of the time.
- Continuously** means the person does the activity 67% to 100% of the time.

Frequency of Occurrence

Activity	N/A	Occasionally	Frequently	Continuously
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Reaching/Working Overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Keyboard Use/Repetitive Hand Motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Activity	Description	Frequency	Weight
<input type="checkbox"/>	Pushing _____	_____	_____ lbs.
<input type="checkbox"/>	Pulling _____	_____	_____ lbs.
<input type="checkbox"/>	Lifting _____	_____	_____ lbs.
<input type="checkbox"/>	Carrying _____	_____	_____ lbs.

Can the job be performed by alternating sitting and standing? YES NO

What are the major tasks requiring the use of one or both hands? Indicate the Percentage of the employee's workday that is spent on each of these tasks.

_____	_____ %
_____	_____ %
_____	_____ %

D. Information About the Job as it Relates to the Disability

Can the job be modified to accommodate the disability either temporarily or permanently? YES NO If "Yes," Explain.

Is it possible to offer the employee assistance in doing the job (e.g., through the use of technology or personal assistance)?

Yes No If "Yes," Explain.

E. Signature

Name (Print) _____	Title _____
Signature _____	Date _____
Telephone Number (____)____-____	Fax Number (____)____-____

FAX, E-MAIL OR MAIL THIS FORM TO:

FAX: 866-597-2187

SECURE E-MAIL WEBSITE – LOGIN & REGISTER AT WWW.SECUREMAIL-BSC.COM

**MOHAWK BENEFITS SERVICE CENTER
6655 TOWN SQUARE, SUITE 250
ALPHARETTA, GA 30005**

