



**Health & Welfare Benefit Systems, Inc.**  
 P.O. Box 21109  
 Roanoke, VA 24018  
 (Office) 800.283.4927  
 (Fax) 540.725.3738  
 (E-mail) [info@hwbs.com](mailto:info@hwbs.com)

**DISABILITY CLAIM FORM**

Employer:	
Employee's Name:	Date of Birth:     /     /
Home Address:	
Social Security Number:     -     -	
Employee's Signature:	Date:     /     /

***EMPLOYER'S STATEMENT***

EMPLOYEE'S NAME:	JOB TITLE AND DUTIES:	PLAN NUMBER:
DATE EMPLOYED: /     /	HOURS WORKED WEEKLY:	If not returned, when expected to return to work?
Date employee last worked? /     /	Was employee terminated? <input type="checkbox"/> YES <input type="checkbox"/> NO	Employer's Name and Address:
To the best of my knowledge and belief all of the answers given by the employee and by me are true and complete? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Signed on behalf of employer by:		Date:
Title:		

***PHYSICIAN INFORMATION***

DATE FIRST CONSULTED FOR THIS CONDITION: /     /	DATE PATIENT IS ABLE TO RETURN TO WORK: /     /	DATES OF TOTAL DISABILITY:
NAME OF REFERRING PHYSICIAN:	DIAGNOSIS OR NATURE OF ILLNESS OR INJURY:	
SIGNED:	PHYSICIAN'S ADDRESS, ZIP CODE AND TELEPHONE NUMBER:     -     -	

**ALL QUESTIONS MUST BE FULLY ANSWERED OR DELAY WILL RESULT**