FORMULA CORPORATION
2919 EAGANDALE BLVD, SUITE 120
EAGAN, MN 55121
651-686-0108, OR 888-686-0412

PROOF OF DISABILITY

EMPLOYEE'S STATEMENT – ALL QUESTIONS MUST BE ANSWERED, PLEASE RETURN COMPLETED FORM TO YOUR EMPLOYER.

1. Name of Employee	Social Security Number | | |-| | |-| | | |	Date of Birth	☐ Male ☐ Female	Employee Marital Status ☐ M ☐ S ☐ Div. ☐ Sep. ☐ Wid.

2. Address Street City State Zip Code Phone Number (required for correspondence)

3. Date Total Disability Commenced	Date Total Disability Ceased	Is Claim Due To An Accident ☐ Yes ☐ No	Date of Accident	Is Claim Due To A Pregnancy ☐ Yes ☐ No

Where Did Accident Occur (if applicable)	Describe Accident (Continue On Reverse If More Space Is Required)

4. Is This Claim The Result Of A Work Related Illness Or Injury? ☐ Yes ☐ No

AUTHORIZATION TO OBTAIN INFORMATION

- I AUTHORIZE my physician, medical practitioner, hospital clinic, other medical or medically related facility, insurance or reinsurance company, the medical information Bureau, Inc., consumer reporting agency or employer, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition treatment of me or my minor children to give to Formula Corporation or its legal representative, any and all such information.
- I UNDERSTAND the information obtained by use of the authorization will be used by Formula Corporation for claim purposes. Any information obtained will not be released by Formula Corporation to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organization performing business or legal services in connection with my claim, or as may be otherwise lawfully required, or as I may further authorize.
- I KNOW that I have a right to receive a copy of this authorization.
- I AGREE that a photocopy of this authorization will be as valid as the original.
- I AGREE that this authorization will be valid for two years form the date shown below.

Employee Signature	Date

ATTENDING PHYSICIAN'S STATEMENT

Diagnosis And Concurrent Conditions-Additional comments can be noted on the back side of this form or included on an attached document

Is Condition Due To Injury Or Sickness Arising Out Of Patient's Employment? ☐ Yes ☐ No	Pregnancy? ☐ Yes ☐ No	If Yes, Date Of LMP	Estimated Date Of Delivery	Actual Date of Delivery	Type of Delivery ☐Vaginal ☐Caesarean

Date of Service (If Previous Forms Submitted To This Carrier, You Need Show Only Dates Since Last Report) If hospitalized, for what dates:
From: Thru:

Date Symptoms First Appeared Or Accident Occurred	Date Patient First Consulted You For This Condition	Patient Was Continuously Totally Disabled (Unable To Work) From: Thru:

If Still Disabled, Please Estimate Date Patient Should Be Able To Return To Work

Physician's Name (Please Print)	Physician's Signature Degree	Date
Address Street City State Zip Code		Telephone Number ( )

EMPLOYER'S STATEMENT

Employee Name	Date Employed	Eligibility Date	Insurance Effective Date
Is This Recurrence Within 2 Weeks Of Previous Disability ☐ Yes ☐ No	Occupation	Weekly Wage $	Weekly Benefit $

Date Last Worked	Date Disability Commenced	Date Disability Ceased	Has Employee Returned To Work ☐ Yes ☐ No	If yes, Date?

Is the employee eligible for Workers Compensation Or Other Disability Income Benefits that may affect this claim? If Yes, Please Explain On Reverse Side ☐ Yes ☐ No	

Employer	Address Street City State Zip Code

Signature of Employer's Representative	Title	Date	Telephone Number ( )