

TO BE COMPLETED BY EMPLOYEE

Please print or type answers to all questions - failure to do so may delay your benefits. Use a separate piece of paper if additional space is needed.

Name: _____

Date of Accident or Beginning of Illness

Date First Unable to Work

Date You Plan to Return to Work (if known)

Describe in your own words what is wrong with you. (If an Accident, describe the circumstances and indicate if the accident occurred at work.)

Should you become unable to handle your own affairs, who is authorized to act on your behalf in matters regarding your Short Term Disability benefits through Loyola University Chicago? (If you wish to designate a representative who may be appointed at a future date, write "future legal designee" or "FLD" as the Name of the Authorized Person/Entity.)

Name of Authorized Person/Entity: _____

Address of Authorized Person/Entity: _____

Telephone Number of Authorized Person/Entity: _____

This is to certify that the facts as indicated above are true to the best of my knowledge and belief. I authorize my healthcare provider(s) to release information to Loyola University Chicago Human Resources for purposes of determining my Short Term Disability benefits.

Employee Signature: _____

Date: _____

