St. Croix Chippewa Indians of Wisconsin
Short Term Disability Claim Form

Fax or Return Competed forms to:

☐ St. Croix Tribal Benefits 715-349-7811 or ☐ St. Croix Casino Turtle Lake 715-986-2133 or ☐ St. Croix Casino Danbury 715-656-7842

Employee Section

Employee Name: __________ Date of Birth: __________

Social Security Number: __________ Phone Number: __________

****IMPORTANT: THIS FORM WILL NOT BE CONSIDERED FOR PAY****
until all three pages (Employee - Physician - Employer) are complete and received by Formula Corporation through your Business Office.

Date last worked (of if still working expected last day*) __________ Next scheduled work day __________

Estimated date of return to work: __________ or If already back, date returned: __________

*For claims submitted in anticipation of future disability, the EMPLOYER IS RESPONSIBLE for contacting Formula Corporation with the actual last day.

Disability due to: ☐ Illness ☐ Injury Date: __________

(If injury, give details of accident below:

Description (how and where): __________

Direct Deposit Option: ☐ Yes ☐ No

If yes, I authorize Formula Corporation and the financial institution listed below to initiate credit entries and if necessary debit entries and adjustments for any credit entries in error to my:

☐ Checking Account ☐ Savings Account

Financial Institution: __________

Account Number: __________

You must attach a voided check for a checking account or a deposit slip for a savings account. This authority will remain in effect unless a written cancellation is received.

I authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, other medically related facility, who has treated or has claim history or medical information about me, to release to Formula Corporation information as to diagnosis, treatment, care and prognosis with respect to any physical or mental conditions of me, for plan administration purposes. I understand that providing false information or omission of relevant information on this form, which materially affects either the acceptance of risk or hazard, may be considered insurance fraud.

Date: __________

____
Employee Signature

St. Croix Chippewa Indians of Wisconsin
Short Term Disability Claim Form

Fax or Return Competed forms to:

☐ St. Croix Tribal Benefits 715-349-7811 or ☐ St. Croix Casino Turtle Lake 715-986-2133 or ☐ St. Croix Casino Danbury 715-656-7842

Physician Section - Please complete in-full to prevent delays in processing

Patient Name: ______ Date of Birth: ______

Diagnosis and Diagnosis Code: ______

Nature of Treatment (including surgery and/or medications) ______

Disability due to:
A) Employment ☐ Yes ☐ No
B) Pregnancy ☐ Yes ☐ No
C) Other ☐ Illness ☐ Injury

If disability is due to pregnancy, please indicate date of delivery:

Actual: ______ or Expected: ______

Date symptoms first appeared: ______ Date of 1st visit for this condition: ______ Next scheduled date for treatment of this condition: ______

Did you refer the patient on to another physician for this condition? ☐ Yes ☐ No If yes, please provide name and telephone number:

Physician Name: ______ Telephone Number: ______

Date patient was disabled (unable to work): From: ______ through ______

If patient is still disabled, give date for anticipated return to work: ______

(patient is required to submit monthly updates)

If patient is allowed to return to work with restriction(s) please specify restriction(s): ______

Physician Name (print or type): ______ Specialty: ______

Facility or Clinic Name: ______

Address: ______

Telephone: ______ Fax: ______

Date: ______

______

Signature of Physician