

Application for Disability Benefits		Employer Name		Mail or Fax to: Innovative Care Systems, Inc. Integrated Disability Claims Department PO Box 11433 , Torrance, CA 90501 800/965-1444 Fax: 310/943-0348	
Use this form to apply for California Voluntary Plan Benefits, STD and LTD benefits.					
To be completed by the Employee (Incomplete forms will be returned)					
Last Name		First Name		Middle Initial	
				Social Security Number -- --	
Address					
City			State		Zip Code
Telephone Number			E-Mail Address		
Date of Birth		Height		Weight	
				Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	
Work Location			Occupation/Job Title		
Did you stop working because of illness/injury/pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No			If "NO" please give the reason:		
Nature of illness/injury (Describe how, when, where):					
Date of accident or when you first noticed symptoms of illness:			If accident, are you seeking damages from another party? <input type="checkbox"/> Y <input type="checkbox"/> N		
			Name/address of other party:		
Last day worked		I have been unable to work because of disability since (date)		I returned to work on (date)	
				Part time Full time	
Is your accident or illness related to your work? <input type="checkbox"/> Yes <input type="checkbox"/> No			If "YES", please explain:		
Have you filed a workers' compensation claim? <input type="checkbox"/> Yes <input type="checkbox"/> No			Has a previous claim for the same disability been made? <input type="checkbox"/> Yes <input type="checkbox"/> No When:		
Do you intend to file a workers' compensation claim? <input type="checkbox"/> Yes <input type="checkbox"/> No			Have you filed for or received Unemployment Benefits since the day you last worked? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Date first treated for illness/injury		Hospital name, location		Doctor name, phone number	
Have you had the same or similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No		Hospital name, location		Doctor name, phone number	
Have you received wages from any other employer or company, including self-employment, in the last 90 days? <input type="checkbox"/> Y <input type="checkbox"/> N		Co. name:		Still employed or on call? <input type="checkbox"/> Y <input type="checkbox"/> N	
		Date other employment began:		Date other employment ended:	
Describe any other income you are receiving or are eligible to receive as a result of your disability, such as Social Security, Workers' Comp, Pension Disability/Retirement, Group Disability, etc.					
Source of Income		Amount of Income	Date Application Filed	Date Income Began	Date Income Ended
I certify that for the period covered by this claim I was unemployed and disabled, that the statements above are true, correct and complete to the best of my knowledge and belief.					
Signature:				Date:	