GROUP WEEKLY INCOME SUPPLEMENTARY REPORT

NOTICE TO EMPLOYEE: THIS FORM IS TO BE COMPLETED AND MAILED TO NORTH AMERICA ADMINISTRATORS, L.P., P.O. BOX 1984, NASHVILLE, TN 37202, UPON RETURN TO WORK OR THE DATE SHOWN BELOW, WHICHEVER OCCURS FIRST.

SOCIAL SECURITY #			DATE OF BIRTH	GROUP NAME
NAME:	LAST	FIRST	MIDDLE	EMPLOYEE'S ADDRESS

AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE ANY HOSPITAL, PHYSICIAN, MEDICAL PRACTITIONER, CLINIC, OR OTHER MEDICAL RELATED FACILITY TO DISCLOSE OR FURNISH TO NORTH AMERICA ADMINISTRATORS, LP, ITS SUBSIDIARIES OR REPRESENTATIVES, ANY AND ALL INFORMATION WITH RESPECT TO ANY ILLNESS (INCLUDING MENTAL ILLNESS) OR INJURY, AND COPIES OF ALL APPLICABLE RECORDS THAT MAY BE REQUESTED. I ALSO AUTHORIZE MY EMPLOYER TO DISCLOSE ALL INFORMATION NEEDED TO PROCESS MY CLAIM.

THE INFORMATION PROVIDED TO NORTH AMERICA ADMINISTRATORS, LP, ITS SUBSIDIARIES OR REPRESENTATIVES, IS TO BE USED SOLELY FOR THE ADMINISTRATION OF CLAIM(S) AS CAPTIONED ABOVE. A PHOTOSTATIC COPY OF THIS AUTHORIZATION IS TO BE CONSIDERED AS VALID AS THE ORIGINAL AND IS EFFECTIVE FOR THE DURATION OF THE CLAIM.

SIGNED ______________________________ DATE ______________

PHYSICIAN'S REPORT

(1) PATIENT'S NAME ______________________________ AGE ________

(2) NATURE OF SICKNESS OR INJURY (DESCRIBE COMPLICATIONS, IF ANY) ______________________________

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(3) (A) DATE OF FIRST TREATMENT ______________________________ 20______

(B) DATE OF MOST RECENT TREATMENT ______________________________ 20______

(C) FREQUENCY OF TREATMENTS ______________________________ 20______

(4) THE PATIENT HAS BEEN CONTINUOUSLY DISABLED (UNABLE TO WORK) FROM ______________ 20____ THROUGH ______________ 20____

IF STILL DISABLED, WHEN SHOULD PATIENT BE ABLE TO RETURN TO WORK? ______________________________ 20____

(5) REMARKS: ______________________________

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SIGNED BY ______________________________ DEGREE ______________ DATE ______________

ADDRESS ______________________________ TELEPHONE # ______________

EMPLOYER'S REPORT

DATE LAST WORKED ______________ 20_____ ❒ A.M. ❒ P.M.

IS THERE ANY POSSIBILITY THIS WAS CAUSED BY EMPLOYMENT? ❒ YES ❒ NO IF YES, EXPLAIN ______________________________

HAS EMPLOYEE RETURNED TO WORK? ❒ YES ❒ NO DATE WORK RESUMED ______________________________ 20_____

IF "NO" IS CHECKED ABOVE, DO YOU EXPECT EMPLOYEE TO RETURN TO WORK? ❒ YES ❒ NO

IF "YES" IS CHECKED ABOVE, GIVE APPROXIMATE DATE ______________________________ 20_____

DATE______________________________ EMPLOYER______________________________

SIGNED BY ______________________________