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) _____

_____

_____

(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: _____

_____

_____

_____

SIGNED BY _____ DEGREE _____ DATE _____

ADDRESS _____ TELEPHONE # _____

EMPLOYER'S REPORT

CURRENT SALARY/WAGES: $ _____

DATE LAST WORKED _____ 20_____ ❒ A.M. ❒ P.M. PER ❒ YEAR ❒ WEEK ❒ HOUR (____ HRS./WEEK)

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 _____