



**CITY OF LINCOLN
EMPLOYEE'S
LONG TERM DISABILITY STATEMENT**

To be completed by employee.

Last Name _____ First _____ Middle Initial _____

Date of Birth _____ S.S. # _____ Male _____ Female _____

Address _____

City _____ State _____ Zip _____

Phone Number (Area Code First) _____

Mailing Address, if different from address above _____

NATURE OF ILLNESS

When did symptoms first appear?

If due to injury, how and when did this accident occur?

Is injury due to employment?

When did you become unable to work because of this disability?

When did you begin your first medical treatment?

How does this illness/injury prevent you from returning to work?

Have you returned to work? ___ Yes (*what date* _____) ___ No Part time _____ Full time _____

If you have not returned to work, on what date do you expect to return to work? _____

Have you engaged in any work, part time or otherwise, during your period of disability? ___ Yes ___ No

If yes, please explain. _____

List the primary physicians that you have consulted because of this disability.

<i>Physician's Name</i>	<i>Address</i>	<i>Phone</i>	<i>Dates Treated</i>
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Have you applied for or are you receiving benefits from:	Applied		Receiving		Date Applied	Amount Received		Effective Date	Paid Thru Date
	Yes	No	Yes	No		Weekly	Monthly		
a. Social Security	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
b. Worker's compensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
c. Salaries, wages, commissions, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
d. Retirement or pension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
e. Veterans disability benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
f. Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

I certify that the above information is true and correct. I hereby authorize all doctors, hospitals or other institutions rendering care to furnish the City of Lincoln with full information regarding treatment rendered (including copies of their records).

Signature _____ Date _____