Independent Contract Mail Drivers' Association
206 North York Road Suite C, Elmhurst, Illinois 60126
Phone: (630) 833-4236•Fax: (630) 833-4762 •E-Mail icmda@att

Disability Claim Form

Name_____

Address_____ _____ City _____ _____ State_____ Zip_____

Phone (home) _____ Cell _____

Part 1- Statement of Insured -You must answer all questions, date and sign

1. On what date, did you last work? Month_____ Date_____ Year 20_____
2. On what date, did you or will you return to work? Month_____ Date_____ Year 20_____
3. Additional remarks_____

_____

_____

_____

Signature_____ _____ Date_____

Part 2 –Attending Physician's Statement

1) Nature of sickness or injury.

2) Describe any other condition or infirmity affecting present condition.

3) List dates and treatments.

4) How long was/ will patient be continuously totally disabled? From Thru

5) Will the patient be partially? disabled? From_____ Thru_____

Attending Physicians Signature_____ Date_____

Address _____ City _____ State_____ Zip_____