



SUPPLEMENTARY STATEMENT FOR CLAIM
 BCI Administrators, Inc. ♦ P.O. Box 250878 ♦ W. Bloomfield, MI 48325-0878
 Phone (248) 626-8896 ♦ Fax (248) 626-8185

INSTRUCTIONS TO EMPLOYEE – CLAIMANT: It is required that periodical reports be submitted for claim determination. No further weekly payments will be made until this Supplementary Report is completed by both you and your attending physician, and provided that you continue to be eligible for additional benefits.

EMPLOYEE’S STATEMENT – If you are still totally disabled complete this form and return by _____ (Date)

1. Your Name: _____
2. Social Security Number: (last 4 digits) _____
3. Your Present Address: _____ Phone: _____
4. Date you first left home and / or hospital since this disability began: _____
5. Briefly describe your daily activities during the past seven days:

Day 1: _____	Day 2: _____
Day 3: _____	Day 4: _____
Day 5: _____	Day 6: _____
Day 7: _____	

6. During the past 30 days did you do any kind of work for yourself or others? Yes No

If "Yes", please describe: _____

I hereby certify the accuracy of the above statements.

Your Signature: _____ Date: _____

(EMPLOYEE – HAVE YOUR ATTENDING PHYSICIAN COMPLETE STATEMENT ON THE OTHER SIDE – THEN PROMPTLY MAIL OR RETURN THIS FORM TO THE PERSONNEL DEPARTMENT.)

EMPLOYER’S STATEMENT	Date Benefits Paid To

1. Did this employee return to work? Yes No If "Yes" give date _____ Hour _____ AM / PM
2. Was an Unemployment or a Worker’s Compensation claim filed since your last report? _____
3. If "Yes", was that claim denied or approved, and date _____
4. Remarks: _____

Date: _____ Completed By: _____



ATTENDING PHYSICIAN'S OR SURGEONS' STATEMENT
(Supplementary Report)

1. Patient's Name: _____ Age: _____ Gender: _____
2. Nature of present disability: _____

3. Date of last treatment: _____ Type of treatment: _____
4. During the past 30 days (or since last report), please list the dates of treatment at:
 Your Office: _____
 Patient's Home: _____
 Hospital: _____
5. (a) Is the above patient currently "house confined"? Yes No Hospitalized? Yes No
 (b) If not confined, what form of activities should the patient be able to do? _____

6. (a) Could the above patient return to work while receiving continued treatment? Yes No
 (b) If "Yes", from what date: _____
 (c) If "No", on or about what date should the patient be able to resume any kind of work? _____
7. Is the above patient totally disabled on this date? _____
8. If the patient is totally disabled as of this date (refer to questions # 7), when will you next be examining this patient to determine if there is a change in disability status? _____

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.

Date: _____ Signed: _____ M.D.
(Attending Physician or Surgeon)

ADDITIONAL COMMENTS: _____

