

RETURN TO → DISABILITY INSURANCE

CLAIMANT NAME:
CLAIMANT ADDRESS:
CLAIMANT ADDRESS:
CITY STATE ZIP:

MAILING DATE:
SSN:

REQUEST FOR CONTINUED BENEFITS

If you will be disabled beyond the original period established on your claim, have your doctor complete and submit the Physician's Supplementary Certificate below to the address listed above. If you are accessing this form online, the certificate must be submitted to the Disability Insurance Office that processed the claim.

PLEASE NOTE: At a later date the Supplemental Certification, DE 2525XX, will automatically be mailed to you as part of the normal Disability Insurance claim process. If your doctor has already completed and submitted this form, you do not need to send any portion of the DE 2525XX to us when you receive it.

If you choose not to submit this form but are disabled beyond your original expected recovery date, then your doctor must complete and submit the DE 2525XX to us within 20 days of that form's mailing date in order for you to receive continued benefits. If the Request for Continued Benefits, DE 2525XXB, is submitted late, you may lose additional benefits.

PHYSICIAN'S SUPPLEMENTARY CERTIFICATE

1. Are you still treating this patient? No Yes If Yes, provide the date of last treatment: _____
2. What is the patient's current disabling condition/injury? Diagnosis: _____
ICD code(s) Primary: _____ Secondary: _____
3. Describe how the patient's current disabling condition or impairment prevents him or her from performing his/her regular and customary work duties.

4. What factors or complications are causing the patient to require more time off from work than previously estimated for this injury or disability?

5. Estimated date this patient will be able to perform his/her regular and customary work: _____
6. Would disclosure of this information to your patient be medically/psychologically detrimental? No Yes

I certify that the above statements accurately describe my patient's condition and the estimated duration of his/her disability.

Doctor's Signature: _____ Date: _____

Telephone (_____) _____ License No. _____

Doctor's Name: _____ State or Country issuing license: _____

Specialty, if any: _____

REGRÉSELO A → DISABILITY INSURANCE

CLAIMANT NAME:
CLAIMANT ADDRESS:
CLAIMANT ADDRESS:
CITY STATE ZIP:

FECHA DE ENVIO:
No. de SS:

PETICIÓN PARA BENEFICIOS CONTINUOS

Si Ud. estará incapacitado(a) más allá del periodo original establecido en su solicitud de beneficios, pídale a su médico que complete y presente la parte titulada en inglés "Physician's Supplementary Certificate" (mostrada abajo) a la dirección indicada arriba. Si Ud. obtiene este formulario en el Internet, el certificado debe ser presentado a la Oficina de Seguro de Incapacidad que tramitó la solicitud de beneficios.

ATENCIÓN: En una fecha futura, le enviaremos automáticamente el formulario titulado en inglés "Supplemental Certification", DE 2525XX, como parte del proceso normal en la solicitud de beneficios del Seguro de Incapacidad. Si su médico ya completó y presentó este formulario, Ud. no necesita regresarnos ninguna parte del DE 2525XX cuando lo reciba.

Si Ud. decide no presentar este formulario pero está incapacitado(a) más allá de su fecha original anticipada de recuperación, en tal caso, su médico deberá de completar y presentar a nuestra oficina el formulario 2525XX dentro de 20 días de la fecha de envío del formulario para que Ud. pueda recibir beneficios continuos. Si la Petición para Beneficios Continuos, 2525XXB, se presenta tarde, Ud. puede perder beneficios adicionales.

PHYSICIAN'S SUPPLEMENTARY CERTIFICATE

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2. What is the patient's current disabling condition/injury? Diagnosis: _____
ICD code(s) Primary: _____ Secondary: _____

3. Describe how the patient's current disabling condition or impairment prevents him or her from performing his/her regular and customary work duties.

4. What factors or complications are causing the patient to require more time off from work than previously estimated for this injury or disability?

5. Estimated date this patient will be able to perform his/her regular and customary work: _____

6. Would disclosure of this information to your patient be medically/psychologically detrimental? No Yes

I certify that the above statements accurately describe my patient's condition and the estimated duration of his/her disability.

Doctor's Signature: _____ Date: _____

Telephone (_____) _____ License No. _____

Doctor's Name: _____ State or Country issuing license: _____

Specialty, if any: _____