DISABILITY PROGRESS REPORT

Sedgwick CMS

- Be sure to answer all questions
- Please type or print
- Please return to XIAP at the address to the right

Xerox Integrated Absence Program
(XIAP)
P.O. Box 9830
Calabasas, CA 91372-0830
Phone: (800) 753-5331
Fax: (800) 921-2758

Employee Name, (last name, first name, middle initial)		

CLAIMANT'S STATEMENT

To be completed and returned ***within 30 days***, if you are still disabled.

[X] If checked, your physician must complete the attached Attending Physician's Statement.

1. Are you still unable to work because of your medical condition? [ ] Yes [ ] No
   If No, what was your recovery date?_____

2. Could you perform another occupation? [ ] Yes [ ] No If Yes, please elaborate: _____
   _____
   _____

3. Provide the complete names and addresses of any medical care provider you consulted with for any condition over the last 6 months:

Complete Name of Care Provider	**Complete Address** (Include Street, City, State, Zip)	**Telephone #** (Include Area Code)

4. List any over the counter medications and prescribed drugs taken for any reason over the last 6 months:

Name of drug/medicine	**Date Rx filled**	**Physician**	**Pharmacy**

5. Provide the complete names and addresses of any hospital/clinic where you received medical treatment, consultation, care or services (including diagnostic measures) over the last 6 months:

Complete Name of Hospital/Clinic	**Complete Address** (Include Street, City, State, Zip)	**Date Treated**

6. Are you receiving any income from any source other than this plan, OR compensation of any kind? [ ] Yes [ ] No
   If Yes, please indicate name and address of payor:_____
   _____

Employee's Signature	Employee's Social Security Number	Date Signed
Name of Personal Representative who has Authority to Sign on Behalf of the Employee	Signature of Personal Representative who has Authority to Sign on Behalf of the Employee	