KLAIS & COMPANY, INC.
EMPLOYEE BENEFIT CONSULTANTS AND ADMINISTRATORS
1867 WEST MARKET STREET
AKRON, OHIO 44313-6977
(330) 867-8443

CONTINUATION OR TERMINATION OF DISABILITY FORM

TO BE COMPLETED BY EMPLOYEE

Employer Name ____________________ Group No. ____________

Name of Employee ____________________ Date of Birth ____/____/____

Address ____________________
Street City State Zip Code

ATTENDING PHYSICIAN'S STATEMENT

Dates of Service: (If previous form submitted to this carrier you need show only dates since last report) ____________________

Concurrent Conditions ____________________

____

Patient still under your care for this condition? ☐ Yes ☐ No If still disabled, date patient should be able to return to work: ____________

Physician's Name (Print) ____________________ Phone No. ____________

Physician's Address ____________________
Street City State Zip Code

Physician's Signature ____________________ Date ____/____/____

EMPLOYER'S STATEMENT

Employee's Name ____________________

☐ Termination of Disability: Date claimant ceased to be disabled ____________ Date returned to work ____/____/____

Employer Name ____________________ Group No. ____________

Signature of Employer Representative ____________________ Title ____________ Date ____/____/____