 Form GBRIB(1)-2

**PHYSICIAN’S FORM FOR VERIFYING**

**CATASTROPHIC ILLNESS OF EMPLOYEE**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name (*Last, First, MI*): | |  | | | | |
| Address (*Street, City, State, & Zip*): | | |  | | | |
| Social Security #: XXX – XX – | | | |  | | |
| Home Phone #: |  | | | | Work Phone #: |  |
| Position: |  | | | | Work Location: |  |

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| **PHYSICIAN’S REPORT OF CATASTROPHIC ILLNESS** |
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| --- | --- | --- | --- | --- | --- | --- | --- |
| Physician’s Name | | Disability Begins  Month Day Year | | | Estimated Date Disability Ends  Month Day Year | | |
| Group Name | |  |  |  |  |  |  |
| Suite Phone Number | | I certify that the above named employee is under my care and will be unable to perform normal job duties during this period. Adjustments in these dates may be necessary at a later date.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Physician’s Signature (No Stamps, Please)  Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Street Address | |
| City, State | Zip Code |