ACCIDENT AND SICKNESS CLAIM FORM

For consideration of benefit approval (check to be issued on payday), application must be received by the prior Friday at 12:00 Noon. SUBMIT completed form to: **Ormet Benefits Department (FAX: 740-483-2658)**

EMPLOYEE STATEMENT (Complete statement below and give to your physician)

Your Full Name: Mr. Mrs. Ms.			Occupation:
Home Phone Number: ( )	Badge No.:	Social Security No.	Date of Birth: Mo. Day Year
Your Address No. Street	City or Town	State	Zip Code
If accident, list date occurred: Provide remarks on next page	Medical Condition you are treating for:	Did the sickness or injury result from your employment at Ormet or any other employment? O Yes O No *If yes, provide remarks on reverse*	*Have you applied for Social Security benefits for your Disability?* O Yes O No If yes, give date applied Mo. Day Year
First day you were unable to work because of disability:	Date you were first treated by physician for present disability:________ Date hospitalized:	If recovery has occurred, give date:	
Your Physician's Name: ________		Your Physician's Phone Number: ________	

I authorize the release to and the use of by Ormet Primary Aluminum Corporation (or their representative) any medical, psychological and/or psychiatric information (excluding psychotherapy notes) that is relevant causally or historically to this claim for Accident and Sickness disability benefits. I understand that the information is being released to my employer for use in administering my claim for Accident and Sickness benefits. This authorization shall remain in effect for the duration of this claim. I also understand that I have the right to revoke this authorization at any time, in writing to my employer but not with respect to any action that has already been taken. I further understand that the release of information to my employer for the purpose of administering Accident and Sickness benefits is exempted from the federal privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and that information disclosed pursuant to this authorization may be redisclosed by my employer and no longer be protected by the federal privacy requirements. I certify that during the period covered by this claim I was disabled and unable to work and earned no wages or remuneration. I authorize the deduction of any overpayment with respect to this claim from any amounts payable to me by or on behalf of the Company, including other benefits, wages, life insurance, workers' compensation, or occupational disease benefits for the same disability period.

Date Signed

PHYSICIAN'S STATEMENT (It is imperative that the following information be accurately and completely reported in order to prevent a delay in benefits to your patient.)

Patient's Name:	Date Patient first consulted you:	Did the sickness or injury result from claimant's employment? O Yes O No
History as related by the patient:		
Describe patient's condition, giving symptoms and objective findings (including current x-rays, EMGs, laboratory & clinical findings:		
What is your diagnosis, based on the above:		ICD-9 code (s):
Is condition due to: O Accident O Illness O Pregnancy	Date Pregnancy commenced:	Expected Delivery Date:
Date of Patient's last visit:	Date of next scheduled Physician appointment:	Frequency of Treatments:
What was the nature of the last treatment?	What is your present plan for treatment?	
What is the prognosis?	Date(s) of outpatient pre-op testing, if any:	
Does the patient have any physical limitations? O Walking O Climbing O Pushing O Pulling O Use of Hands	If limitations, please explain:	
Date of Hospital confinement: From: Through:	Surgical Procedures performed and date:	
If still disabled, what is the earliest date patient will be no longer totally disabled? (will be able to work):		
By my signature below, I certify that the above patient was continually totally disabled as a result of sickness or accident so as to be prevented from performing the duties of his/her employment: From Through		
Physician's genuine signature:	Date Physician signed report:	
Physician's name typed or printed legibly:	Physician's phone number:	
Physician's address:	Physician's fax number:	

EMPLOYER STATEMENT: (TO BE COMPLETED BY THE ORMET BENEFITS OFFICE)

Verify Employee's Badge Number:		Work Location/Position:	
Verify Employee's name:		Verify Social Security Number:	
Was Employee laid off or was layoff contemplated prior to beginning of disability? O Yes O No If Yes, give date: Mo. Day Year	Were benefits in force when disability began? O Yes O No	Date of Employment: Waiting Week if Applicable:	
Is there any indication that this is a Workers' Comp claim?	Weekly Rate:	Did employee receive salary continuance? If yes, through what date:	
Date Employee last worked: Mo. Day Year	Date Returned to Work: Mo. Day Year	O Initial Claim O Subsequent Claim	
Signed:		Date:	

Important Notice

Notice to all parties completing this form: Any person who knowingly and with intent to defraud any insurance company or other person, files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. Criminal and/or civil penalties can result form such acts. (Please see state specific fraud warnings) * This warning does not apply to Virginia Residents.

Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Remarks Section