G&W Equipment, Inc.

SHORT TERM DISABILITY CLAIM FORM

EMPLOYEE SECTION:

EMPLOYEE'S NAME:_____DATE OF BIRTH: _____

SOCIAL SECURITY #: _____ SEX: _____ MARITAL STATUS:_____

ADDRESS:_____

HOME TELEPHONE #: _____CELL #: _____

DESCRIBE THE NATURE OF YOUR ILLNESS OR INJURY:_____

_____

DATE OF INJURY OR ILLNESS:_____DATE OF FIRST TREATMENT: _____

ARE YOU UNABLE TO WORK BECAUSE OF THIS INJURY OR ILLNESS?_____

WAS ILLNESS OR INJURY RELATED TO YOUR WORK EMPLOYMENT?_____

DID YOU REPORT THIS INJURY TO YOUR IMMEDIATE SUPERVISOR?_____

IF "YES" HAVE YOU FILED A WORKER'S COMP CLAIM?_____

IF "YES" STATUS OF WORKERS COMP CLAIM FILED: _____

ARE YOU CURRENTLY WORKING? _____DATE YOU EXPECT TO RETURN TO WORK: _____

I,_____authorize any physician, medical practitioner, hospital, clinic, other health facility, the Medical Information Bureau, insurance or reinsurance company, or employer to release any and all medical and non-medical information about me in its possession to G&W Equipment or its legal representative. Medical information means all information in the possession of or derived from providers of health care regarding my medical history, mental or physical condition, or treatment. I understand that G&W Equipment will use the information obtained by this authorization to determine eligibility for benefits under the current existing plan. G&W Equipment will not release the information obtained to any unauthorized person or organization not related to this claim. I agree that a photocopy of this authorization shall be as valid as the original. I agree that authorization shall be valid for the duration of my claim. I have the right to cancel this authorization in writing at any time.

SIGNATURE OF EMPLOYEE_____DATE_____

SIGNATURE OF G&W REPRESENTATIVE _____

FRAUD: ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL PROSECUTION.