THE PENNSYLVANIA STATE UNIVERSITY
Employee Benefits Division
James M. Elliott Building, University Park, PA 16802

SICKNESS AND ACCIDENT SUPPLEMENT (SAS) CLAIM FORM

SECTION 1: TO BE COMPLETED BY EMPLOYEE - PLEASE PRINT

1. _____ _____ _____ _____
   Employee Name PSU ID No. Date of Birth Sex

2. College or Department:_____

3. Is this claim the result of a work-related illness or injury? _____Yes _____No
   If yes, furnish details: _____
   _____

4. What is the nature of your illness or injury: _____
   _____

5. Date of injury or beginning of illness:_____
   _____

6. How long do you expect the disability to continue: _____
   _____

7. Are you covered by another sickness and accident plan? _____Yes _____No
   If yes, furnish name and address of company:_____

8. Have you filed for:

	Yes	No
Social Security	_____	_____
Worker's Compensation	_____	_____
Disability Retirement Benefits	_____	_____

9. Date(s) and name(s) and hospital(s) providing treatment

Date	Physician	Hospital

I hereby certify that the above statements are correct and I authorize the release of information from the above named physician(s) and hospital(s).

_____ _____ _____
Employee's Signature Home Address Date

SECTION 2: TO BE COMPLETED BY ATTENDING PHYSICIAN

Patient's Name:_____

Diagnosis and concurrent condition:_____

Is condition due to injury arising out of patient's employment? ___ Yes ___No

Report of service:

Dates of Service	**Place of Service**	**Description of Surgical or Medical Services Rendered**

Is employee expected to return to work? If so, approximate date: _____

_____
Physician's Signature

_____ _____ _____
Physician's Name (print) Degree Date

_____ _____ ____ _____
Street Address City State Zip Code

SECTION 3: TO BE COMPLETED BY EMPLOYEE'S HUMAN RESOURCES REPRESENTATIVE OR DIRECTOR OF BUSINESS SERVICES

Has employee used more than six (6) sick days of accumulated sick leave without doctor's certification in the twelve (12) month period immediately preceding the absence? _____Yes _____No

Normal days off _____ _____

_____ _____
Name of HRR/DOBS Phone Number

_____ _____
Date employee's absence commenced Employee's hourly rate

_____
Last day employee received full pay

Please include a copy of Employee's Vacation/Sick Leave Record(s)

COMPLETED FORM MUST BE RETURNED TO
EMPLOYEE BENEFITS DIVISION
JAMES M. ELLIOTT BUILDING, UNIVERSITY PARK, PA 16802