

MURPHY OIL USA
Superior Refinery
Superior, Wisconsin

APPLICATION FOR SICKNESS & DISABILITY BENEFITS

(Please return promptly. Benefits will not be paid until application is received and processed.)

EMPLOYEE'S STATEMENT

I, _____, hereby certify that I am disabled with _____
_____ since _____ and cannot perform the duties in connection with my
_____ Date
employment during said disability. I further certify that I will not work elsewhere during such disability.

Signature: _____ Date _____

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DOCTOR'S STATEMENT

Name of Patient _____ Date first under your care _____
_____ Diagnosis _____

Was the patient hospitalized _____ If so, give date _____

Did the patient have outpatient surgery? _____ If so, give date _____

If employee claims this is an occupation illness, what evidence is there that the disability is due to the patient's
occupation? _____

_____ Approximate date he/she may return to work _____

I hereby certify that this illness has made it impossible or undesirable for this employee to carry on his/her regular
duties during this absence.

Signature _____ M. D.

Address _____

Date _____

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TO ADMINISTRATIVE SERVICES

Comments: _____