

DISABILITY INCOME INSURANCE FORM

United States Letter Carriers



Mutual Benefit Association

U.S. LETTER CARRIERS

MUTUAL BENEFIT ASSOCIATION

100 INDIANA AVENUE, N.W. SUITE #510

WASHINGTON, DC 20001

(202) 638-4318

Official Use Only

PART "A" MEMBER'S STATEMENT

A. MEMBER'S INFORMATION

1. Name of Member _____ Policy Number _____
 Address _____ Telephone Number (____) _____
 _____ Social Security Number _____
2. NALC Branch Number _____ Name of Branch President _____

B. INSTRUCTIONS This form is furnished to assist you in presenting a claim for benefits. Medical certification is required for the entire period you are disabled. Please follow the instructions below and be sure you, your physician, and your supervisor answer all questions on the form, sign and date it. If additional space is needed, attach a separate sheet of paper.

- I. This form **MUST** be completed **AFTER** the appropriate Elimination Period has been met.
- II. The three sections of this form must be completed in full by the appropriate person as follows:
 - 1. Part "A" by you (Member should not complete any information on Parts "B" and "C")
 - 2. Part "B" by your Physician (Medical records from the providers **MUST** be sent with this claim)
 - 3. Part "C" by your Employer (if more than one employer attach separate sheet(s) with information).
- III. All questions must be completed in full to avoid delays in processing your claim.
- IV. Please print or type clearly.
- V. Medical records from the providers **MUST** be sent with this claim.

C. DEFINITION: ELIMINATION PERIOD means the number of days, beginning with the day your total disability starts, for which no disability benefits are provided. It is shown in the Schedule of Benefits and Premiums Section of your policy. If you have questions concerning your elimination period call U.S. Letter Carriers Mutual Benefit Association, (202) 638-4318.

D. TO BE COMPLETED BY THE MEMBER

AUTHORIZATION TO RELEASE INFORMATION

I authorize any licensed physician; medical practitioner; hospital; clinic or other medical or medically related facility; insurance company, including if applicable, the NALC Health Benefit Plan; government organization; Social Security Administration; other organization; institution or person that has any records or knowledge of me, my health (including any information relating to use of drugs or use of alcohol and any information relating to mental and physical history, condition, advice or treatment); earnings or other insurance benefits to release this information to the Mutual Benefit Association or it's duly authorized representatives.

I further understand that in executing this authorization, information obtained by it will be used for evaluating and administering a claim for benefits and that I have waived the right for such information to be privileged.

A Photostat copy of this authorization is to be considered as valid as the original and is effective for the duration of the claim. I certify that the information furnished by me in support of the claim is true and correct to the best of my knowledge and belief.

Several States require that this or a substantially similar statement appear on all claim forms:

The undersigned acknowledges that, any person knowingly and with intent to injure, defraud, or deceive any insurance company or other person, files a claim containing any materially false or deceptive information, or conceals for the purpose of misleading, information concerning any fact materially, thereto, commits a fraudulent insurance act which is a crime.

Claimant's Signature

Date

PART "A" MEMBER

- 1. Complete AFTER the appropriate elimination period has been met.
- 2. Complete ALL Sections of claim form

E. INFORMATION ABOUT THE CONDITION CAUSING YOUR DISABILITY

1. For **Illness, Injury, or Complication of Pregnancy**, answer the following questions:
 - a. What were your first symptoms _____
 - b. Date you first noticed symptoms _____ Date you were last treated by a physician _____
2. Have you had the same or similar condition(s) in the past? YES NO If yes, list condition(s) and date(s) of treatment _____
3. If any Injury, list date of accident, place and nature of accident _____

F. INFORMATION ABOUT THE DISABILITY

1. Is your condition related to your occupation? YES NO If yes, explain _____
2. Have you filed, or do intend to file a Worker's Compensation claim? YES NO If, yes date _____
3. **Have you returned to work?** YES NO If yes, **Part Time(date)** _____ **Full Time (date)** _____
4. If you have not returned to work, do you expect to? YES NO If yes, Part Time (date) _____ Full Time (date) _____
5. Have you retired from work? YES NO If yes, provide **Notification of Personnel Action (PS FORM 50)**

G. INFORMATION ABOUT MEDICAL TREATMENT, PHYSICIANS, HOSPITALS AND TREATMENT CENTERS

1. FIRST medical attention for the current disability was given by the following provider(s):

<u>Date</u>	<u>Name</u>	<u>Address</u>	<u>Telephone Number</u>
_____	_____	_____	() _____
_____	_____	_____	() _____
_____	_____	_____	() _____
2. List all other providers you have seen for this condition(s):

<u>Date</u>	<u>Name</u>	<u>Address</u>	<u>Telephone Number</u>
_____	_____	_____	() _____
_____	_____	_____	() _____
_____	_____	_____	() _____
3. Have you received treatment for the same or similar condition(s) in the past? YES NO If yes, list all Provides below:

<u>Date</u>	<u>Name</u>	<u>Address</u>	<u>Telephone Number</u>
_____	_____	_____	() _____
_____	_____	_____	() _____
_____	_____	_____	() _____

H. OTHER EMPLOYMENT, GROUP HEALTH AND DISABILITY INSURANCE

1. **Are you working at any other gainful occupation or job?** YES NO If yes, complete information below:
 Name of Employer _____ Address _____
 Immediate Supervisor's Name/Title _____ Telephone Number () _____
2. List other Group Health and Disability Insurance

<u>Name</u>	<u>Address</u>	<u>Telephone Number</u>	<u>Type of Policy</u>
_____	_____	() _____	_____
_____	_____	() _____	_____
_____	_____	() _____	_____

I. CLAIMANT'S SIGNATURE:

I certify that the information furnished by me in support of this claim is true and correct to the best of my knowledge and belief.

Signature of Claimant

Date

Claimant--This claim may be delayed if the attending physician does not fully complete this form.

- PART "B" ATTENDING PHYSICIAN**
1. Part B to be completed by physician's office ONLY.
 2. Each attending physician must complete a separate claim form
 3. Medical records relating to this disability must be attached.

A. GENERAL INFORMATION

1. This claim is for (Patient's Name) _____
2. Social Security Number _____

B. COMPLETE THIS SECTION FOR PREGNANCY

1. Is this a **NORMAL** pregnancy? YES NO If yes, complete **Section E**.
2. Is this a **COMPLICATION** of pregnancy? YES NO If yes, complete **Sections C, D and E**.
3. If **Complication of Pregnancy**, Date of the last menstrual period? _____, Expected date of delivery _____ First date of treatment _____, Expected length of postpartum recovery _____, Last date of Treatment _____

C. COMPLETE THIS SECTION FOR ALL CONDITIONS

1. Primary Diagnosis including **ICD 9** or **DSM Code(s)** _____
2. For Illness or Accident what date did the first symptoms appear? _____
3. State briefly the Objective Findings _____
4. Are there secondary conditions contributing to the disability? YES NO If yes, What are they? _____
5. Indicate other conditions and frequencies of treatment for which the patient is receiving treatment _____
6. Is the patient's condition work related? YES NO If yes, Explain _____
7. **Date** of patient's **first visit** for disability (MM/DD/YYYY) _____ How often do you see the patient? _____
8. **"Date"** YOU advised patient to discontinue work _____ Date of patient's last visit _____
9. Have you released the patient to return to **"ANY"** type of employment? If yes, list **"Date"** of release (MM/DD/YYYY) _____
10. Has the patient been hospital/facility confined? YES NO If yes, give date of confinement _____ to _____
11. What medication is the patient currently taking? _____
12. Have you referred the patient for other types of consultations, medical rehabilitation or therapy program? YES NO If yes, explain _____
13. Has the patient undergone surgery? YES NO If yes, give date and type of surgery _____
14. Do you expect surgery to be performed in the future? YES NO If yes, give date and type of surgery _____
15. If this is a cardiac condition, what is the functional capacity? (American Heart Association)
 CLASS 1 – No limitation CLASS 3 – Marked limitation
 CLASS 2 – Slight limitations CLASS 4 – Complete limitation

D. INFORMATION ABOUT THE PATIENT'S INABILITY TO WORK

1. Briefly describe restrictions and limitations _____
2. What is your prognosis for recovery? _____
3. Has the patient achieved maximum medical improvement? YES NO If no, how soon do you expect fundamental changes in the condition:
 1 – 2 Months 5 – 6 Months
 3 – 4 Months more than 6 months
Give details concerning expected improvement or deterioration _____

E. DOCTOR: Your opinion on the degree of disability is essential, therefore we ask that you, as the attending physician, personally sign this report. Your signature is certifying that the information furnished by you in support of this claim is true and correct to the best of your knowledge and belief.

Date _____

Signature of Attending Physician (**NO stamp**) _____ Degree _____ Specialty _____
Attending Physician's Name (Print or Type) _____ Federal ID Number or Social Security Number _____
Street Address _____ City _____ State _____ Zip Code _____
Telephone () _____ Fax: () _____

PART "C" EMPLOYEE'S SUPERVISOR

1. Part C to be completed by the Employer ONLY.
2. Each Employer (Full or Part time) must complete a separate form.

A. GENERAL INFORMATION

1. This claim is for (Employee's Name) _____ Social Security Number _____
2. Job Title _____ Are you the Primary Employer? ___ YES ___ NO
3. Date disability began _____ **First day claimant did not work because of disability** _____

B. INFORMATION ABOUT THE JOB AS IT RELATES TO THE DISABILITY

1. Has the Claimant returned to any type of work? ___ YES ___ NO
If yes, (a) performed **REGULAR DUTY** on (MM/DD/YYYY) _____
(b) performed **LIGHT or LIMITED DUTY** on (MM/DD/YYYY) _____
2. Claimant has been released to return to **LIGHT DUTY WORK** but **LIGHT DUTY** is **NOT** available, explain _____
3. Has the claimant retired from work due to disability? ___ YES ___ NO If yes, provide **Notification of Personnel Action (PS FORM 50)**
4. Other comments you may wish to make relative to this disability claim _____

C. EMPLOYER: The information concerning this disability is essential, therefore we ask that you as the employer personally complete and sign this report. I certify that the information furnished by me in support of his claim is true and correct to the best of my knowledge and belief.

Date: _____

Signature of Supervisor (**NO Stamp**) _____ Title _____
Name of Supervisor (Print or Type) _____ Station or Unit Name _____
() _____
Telephone Number _____