

**MEBA Medical & Benefits Plan 1007 Eastern Avenue Baltimore, MD 21202-4345  
410-547-9111 \* 800-811-MEBA (Toll-Free) \* 410-659-1675 (Fax) \* www.mebaplans.org  
Short Term Disability Claim Form for Members**

**PART I MUST BE COMPLETED AND SIGNED BY MEMBER OR RESPONSIBLE GUARDIAN IF MEMBER IS NOT AVAILABLE. (NOTE THAT THE MEMBER MUST SIGN THIS FORM IF THERE IS ANY CHANGE OF ADDRESS.)**

**IMPORTANT: FAILURE TO FULLY ANSWER ALL QUESTIONS MAY DELAY THE FINALIZATION OF YOUR CLAIM.**

Member Name		Last Name		First Name		Initial	
Social Security Number		[ ] [ ] [ ] - [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]					
Date of Birth		/ /		Sex (Check One)		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Telephone Number		(Area Code: [ ] [ ] [ ] )		[ ] [ ] [ ] - [ ] [ ] [ ] [ ] [ ] [ ]			
Permanent Address (Home of Record)		Number and Street		City		State Zip	
New Address? <input type="checkbox"/> yes <input type="checkbox"/> no		Number and Street		City		State Zip	
Mailing Address (If Other than Permanent Address)		Number and Street		City		State Zip	
Is your condition due to an accident?		<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, furnish date, place and description of accident:			
Past or Present Employer		Vessel		Rating			
Employment Dates		From: Thru:		Foreign Articles?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Did you leave ship before the end of the voyage?		<input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, date and reason:		Did you leave ship For vacation?	
If you were hospital confined do you wish to collect vacation and disability concurrently?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Have you worked since start of this disability?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Did you receive any sick pay from your Employer?						<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had any employment with any employer contributing to a State Disability Plan in last 19 months?						<input type="checkbox"/> Yes <input type="checkbox"/> No	
I understand that it is a violation of the rules for me to work under the authority of my license (including night/relief work) during the period for which I am collecting disability benefits. I further understand that I cannot receive vacation pay and disability benefits concurrently unless I was hospital confined for at least one day during my disability period.							
I HEREBY CERTIFY THAT ALL OF THE ABOVE STATEMENTS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE AND BELIEF. I AUTHORIZE ANY INSURER, HOSPITAL, PRACTITIONER OR OTHER PERSON(S) TO DISCLOSE ANY INFORMATION REGARDING MY (OR MY DEPENDENT'S) INSURANCE COVERAGE OR MEDICAL HISTORY.							
DATE		SIGNATURE (IF OTHER THAN MEMBER, SHOW RELATIONSHIP)					
<b>Part II APPLICATION FOR DISABILITY BENEFITS</b>							
THE FOLLOWING MUST BE COMPLETED BY THE ATTENDING PHYSICIAN							
Date of First Symptoms or Accident:		Date Patient First Consulted You for This Condition:					
Diagnosis or Illness						<input type="checkbox"/> Yes <input type="checkbox"/> No	
Patient Ever Had Same or Similar Condition?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Patient Still Under Your Care for This Condition:		Date of Next Appointment:	
Dates Patient Was Continuously Disabled (unable to work):		From: Through:		If Still Disabled, Date Patient Should be Able to Return to Work:			
Physician's Name (print)		Last Name		First Name		Initial	
Physician's Address		Number & Street		City		State Zip	
Physician's Phone Number		(Area Code: [ ] [ ] [ ] )		[ ] [ ] [ ] - [ ] [ ] [ ] [ ] [ ] [ ]			
Physician's Signature & Date							