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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	*Month* / *Day* / *Year*	Sex (Check One)	☐ Male ☐ Female	
Telephone Number				
Permanent Address (Home of Record) New Address? ○ Yes ○ 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? ○ Yes ○ No	If yes, furnish date, place and description of accident:			
Past or Present Employer		Vessel	Rating	
Employment Dates	*From* / *Through*	Foreign Articles? ○ Yes ○ No		
Did you leave ship before the end of the voyage? ○ Yes ○ No	If yes, date and reason:	Did you leave ship for vacation? ○ Yes ○ No		
Have you worked since start of this disability? ○ Yes ○ No	If yes, name of Employer, Vessel and dates: *Employer* / *Vessel*	*From* / *Through*		
Did you receive any sick pay from your Employer? ○ Yes ○ No				
Have you had any employment with any employer contributing to a State Disability Plan in last 19 months? ○ Yes ○ 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)			

Part II: APPLICATION FOR DISABILITY BENEFITS

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		Is patient still under your care for this condition? ○ Yes ☐ No		
Dates patient 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 and Street*	*City*	*State*	*Zip*
Physician's Phone Number				
Physician's Signature	Date			