UNITED STATES LETTER CARRIERS MUTUAL BENEFIT ASSOCIATION
100 Indiana Avenue, N.W. Suite #510
Washington, D.C 20001-2144
(202) 638-4318

IMPORTANT INFORMATION ABOUT FILING A DISABILITY CLAIM

PLEASE BE ADVISED ALL QUESTIONS MUST BE COMPLETED IN FULL TO AVOID DELAYS IN PROCESSING YOUR CLAIM

PHYSICIAN'S RECORDS – (IMPORTANT)

All physician's medical records pertaining to your disability must be filed with each claim form. **Failure to provide this information may delay the processing of your claim**.

PROOF OF LOSS

Disability claim payments will only be made after written proof of loss is provided to our executive office. There will be no payments made for future dates of total disability. If you have any questions on any of the information provided on these sheets, please do not hesitate to contact our office at (202) 638-4318.

ELIMINATION PERIOD

Please be advised that you **must wait until after you have satisfied the ELIMINATION PERIOD** to have the claim form completed. If you have any questions regarding the Elimination Period for your claim, please refer to the SCHEDULE OF BENEFITS AND PREMIUMS page of your policy.

AVOID DELAYS

To avoid delays in the processing of your claim, **please review your claim to insure all of the questions have been fully answered**. All appropriate signatures and dates should be affixed to the claim form, The Insured must not complete any portion of the Physician's section or the Supervisor's section. MBA DOES NOT ACCEPT FAXED OR PHOTOCOPIED CLAIM FORMS.

WAIVER OF PREMIUMS

Remember that **until your disability claim has been approved, all premiums must be kept at a current status**. After satisfying the Elimination Period for your claim, any premium that you have paid while your total disability continues and the monthly benefit is being paid, will be refunded (see the **WAIVER OF PREMIUM** section of your policy).

PROCESSING A CLAIM

Note that after all of the necessary information regarding a claim has been received by our office, the typical processing time for a claim is 2–3 weeks. This time may vary depending on the number of claims we receive in our office.

BENEFIT CHECK AMOUNTS

The actual amount of each benefit check may vary from your monthly indemnity amount. Payment is based upon the dates for which our office has written verification that you met the requirements of TOTAL DISABILITY, as defined by your policy. This verification is provided to the MBA on the claim form by the signatures and dates of your physician and P.O. Supervisor.

CONTINUING DISABILITY

For continuing periods of disability, you will be required each month to submit a Supplementary Statement of Continuing Disability, until your claim has ended.

WRITTEN PROOF OF LOSS

The disability Income Insurance policy requires you to give us written proof of loss, unless it is not reasonably possible for you to do so, within 90 days after the end of each period for which we are liable, and it absolutely requires you to give us proof of loss within one year after the period for which we are liable unless you are legally incapacitated. Please review your policy, which sets out your and our rights and obligations.

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):

Date	**Name**	**Address**	**Telephone Number**
________________	____________________	_______________________	( ) ____ ___________
________________	____________________	_______________________	( ) ____ ___________
________________	____________________	_______________________	( ) ____ ___________

2. List all other providers you have seen for this condition(s):

Date	**Name**	**Address**	**Telephone Number**
________________	____________________	_______________________	( ) ____ ___________
________________	____________________	_______________________	( ) ____ ___________
________________	____________________	_______________________	( ) ____ ___________

3. Have you received treatment for the same or similar condition(s) in the past? ____YES ____NO If yes, list all Provides below:

Date	**Name**	**Address**	**Telephone Number**
________________	____________________	_______________________	( ) ___ ____________
________________	____________________	_______________________	( ) ___ ____________
________________	____________________	_______________________	( ) ___ ____________

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

Name	**Address**	**Telephone Number**	**Type of Policy**
________________	__________________________	( ) ____ _______________	__________________
________________	__________________________	( ) ____ _______________	__________________
________________	__________________________	( ) ____ _______________	__________________

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