Statement of Claimant as to Disability

Note: Complete <u>all</u> questions fully, otherwise payment will be delayed or declined.

Full Name (please print) _____ Age _____

Date when you became disabled _____

Last date you worked prior to illness or injury (or same date?) _____

Occupation _____ Date of Birth _____

What was the nature of your disability? Give full details _____
_____
_____

Have you ever had the same kind of illness? Y / N If so, when? _____

Dates you were treated by a physician _____

Have you applied for medical retirement? Y / N If so, when? _____

Have you received a medical retirement or voluntary separation from employment?
Y / N If so, when? _____

Date you returned to work (Or "Still disabled") _____

I, the undersigned, do hereby warrant the foregoing answers and statements to be correct and true, without evasion or reservation, and I agree that if they are found to be untrue all rights under the By-Laws of the Association shall be void.

Claimant Signature _____ Date _____

Address _____

City, State, Zip _____

Phone _____

Physician's Statement

Note: SP&S Use only. No claim will be paid without a Physician's Statement.

Claim No_____ Claimant's Name_____

Name_____

Diagnosis (illness or injury)_____

Disabled From_____ To_____ Days_____

Was any operation performed? Y / N
If so, what? _____

Date of previous claim _____ Date Paid _____

Claimant's condition at last visit _____

Dates claimant unable to work at their occupation
From _____ To _____

Class _____ Amount Paid _____

Unpaid dues withheld _____

Physician Signature _____ **Date** _____

Mail claims to:

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