



Los Angeles Firemen's Relief Association
Widows, Orphans & Disabled Firemen's Fund
 P. O. Box 41903
 Los Angeles, CA 90041
 (800) 244-3439 or (323) 259-5200 x223 or x222
 www.lafra.org

Application for Sick or Injury Benefits (Active)

Member Information:

Member's Full Name:		Social Security Number:	Birth Date:	Today's Date:
Address:	City:	State:	Zip:	
Telephone Number:	Email Address:		Assignment:	

The Association hereby expressly reserves the right to interpose any and all legal defenses it may have to your claim, including any objection to the proof furnished by you either as to substance or form.

This Association claims that a sickness or accident, serious enough to cause the member to make a claim for benefit, **requires a physician. Kindly have the physician who attended you** fill out the report on the other side of this form.

I, _____ was taken (ill-injured) and for the purpose of receiving the benefit to which I am entitled, I answer, under oath, the following questions:

Describe in your own words the nature and circumstances regarding your illness or injury (include DATE, TIME and LOCATION).

2. Was it a recurrence of an old injury or illness? Yes No
3. When did you first see a physician in regard to this illness? (or injury)? _____
4. State his name and address in full: _____
5. How long were you wholly disabled in consequence of said illness or injury from the prosecution of every part of your duties or occupation? (Give length of time between what dates) from: _____ to _____
6. Were you in the hospital? Yes No If yes, from: _____ to _____
7. How often do you see the doctor (check square that applies – If other, indicate in detail)
 DAILY WEEKLY SEMI-MONTHLY MONTHLY OTHER
 Other: _____
8. Are the above visits for: Check up or Treatment

By my signature below, I authorize all Hospitals and/or Doctors to release my medical records for inspection and/or transcription or photocopy as well as for inspection of charges. A photocopied copy of this shall be as effective as the original.

Note: In no case shall benefits be allowed for a fractional part of a day. If disability begins before Midnight the entire day shall be allowed. I declare under penalty of perjury that the foregoing is true and correct.

Member's Signature: _____

Dated _____, 20_____, at (City and State) _____

We, the Claims Committee, hereby certify that we have examined this claim, and we recommend the payment of:

Daily _____ days @ _____
25% _____ days @ _____
50% _____ days @ _____
LNP _____ days @ _____
Total Amount: _____
Less Advance: _____
BALANCE: _____

(Claims Committee)

Chairman

BOARD APPROVAL

ATTENDING PHYSICIAN'S FINAL STATEMENT
IMPORTANT: THIS MUST BE FILLED OUT BY THE PHYSICIAN WHO ATTENDED YOU

Disability resulting from illness (injury) implies that the patient has been materially prevented from engaging in his normal activities or occupation. Benefits provided for in this Association do not cover trivial and unimportant sickness or injury, which causes great inconvenience by which does not cause disability. The physician making this report is requested to answer questions No. 5 and 9 fully.

In evidence of the claim of _____
 (Member's Name)

(Attending physician or practitioner must answer every question fully and accurately and add such other information as may be in his or her possession relating to this claim.)

1.

Physician's name:				Telephone:		
Address:		City:		State:		

2. Are you a licensed Physician?: Yes No

3. Have you recently attended the above named member for illness or injury? If so, when were you first consulted or called, and where did you attend him/her? _____

4. What was the precise nature of the illness or injury, and it's extent? _____

5. Is this an on duty work comp injury? _____

6. Is this a possible recurrence of an old injury or previous illness? _____

7. Was the applicant under the influence of intoxicating drinks or narcotics when he/she became incapacitated? _____

8. Was patient in the hospital? _____ From: _____ To: _____

9. IN MY OPINION, THE PATIENT WAS ACTUALLY DISABLED AND UNABLE TO CONTINUE NORMAL ACTIVITY, DUE TO THE ILLNESS OR INJURY, from the _____ day of _____, 20____, to the _____ day of _____, 20____

10. Has patient been released from your care for this illness or injury to continue normal activity? _____

a. If so, when?

11. If the patient is still under your care – are you seeing him/her regularly? Yes No

If yes, is it for treatment or Check-up

Physician's Signature: _____

Date: _____ at _____

(City and State)