**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 (Retired)

## Member Information:

| Member's Full Name: | Social Security Number: | Birth Date: | Today's Date: |
|---|---|---|---|
| | | | |

| Address: | City: | State: | Zip: |
|---|---|---|---|
| | | | |

| Telephone Number: | Email Address: |
|---|---|
| | |

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. If employed within seven days prior to this illness/injury answer the following:
   a. Were you disabled or prevented from engaging in your occupation by this illness/injury? ☐ Yes ☐ No
6. If not employed, were you disabled or prevented from engaging in your normal activities by this illness/injury? ☐ Yes ☐ No
7. Have you recovered from this illness/injury to continue normal activity? ☐ Yes ☐ No
8. Were you in the hospital? ☐ Yes ☐ No If yes, from: _____ to _____
9. How often do you see the doctor (check square that applies – If other, indicate in detail)
   ☐ DAILY ☐ WEEKLY ☐ SEMI-MONTHLY ☐ MONTHLY ☐ OTHER
   Other: _____
10. 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:

| | |
|---|---|
| _____ Days, at | $ _____ per day |
| 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 im/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)