



LOS ANGELES FIREMEN'S RELIEF ASSOCIATION

P.O. Box 41903 | Los Angeles | CA 90041
(323) 259-5200 EXT. 223 or 222 firemensrelief.org

APPLICATION FOR SICK OR INJURY BENEFITS (ACTIVE)

<<< PLEASE USE BLUE INK PEN / FAX (323) 259-5223 or (323) 259-5222 >>>

MEMBER INFORMATION

FULL NAME		LAST 4 DIGITS OF SSN		BIRTH DATE	TODAY'S DATE
ADDRESS			CITY	STATE	ZIP
HOME PHONE	CELL PHONE	EMAIL ADDRESS			
APPOINTED TO LAFD ON:			CURRENT 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).

Was it a recurrence of an old injury or illness? YES NO

When did you first see a physician in regard to this illness? (or injury)? _____

State his name and address in full: _____

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 _____

Were you in the hospital? YES NO If YES, FROM _____ TO _____

How often do you see the doctor (check square that applies - If other, indicate in detail)

DAILY WEEKLY SEMI-MONTHLY MONTHLY OTHER

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: _____ Date: _____ 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

<<< PLEASE USE BLUE INK PEN >>>

Disability resulting from illness (injury) implies that the patient has been materially prevented from engaging in normal activities. 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.

In evidence of the claim of _____

(MEMBER'S NAME)

ATTENDING PHYSICIAN OR PRACTITIONER MAKING THIS REPORT IS REQUESTED TO ANSWER EVERY QUESTION ACCURATELY AND ADDITIONAL INFORMATION AS NEEDED RELATING TO THIS CLAIM. QUESTIONS NUMBER 5 THROUGH 9 MUST BE ANSWERED FULLY.

PHYSICIAN'S INFORMATION

PHYSICIAN'S NAME			
ADDRESS	CITY	STATE	ZIP
PHONE	FAX	EMAILADDRESS	

2. Are you a licensed Physician? YES NO

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

4. What was the precise nature of the illness or injury, and its extent?

5. Is this an on duty work comp injury? **(MUST BE ANSWERED FULLY)**

6. Is this a possible recurrence of an old injury or previous illness? **(MUST BE ANSWERED FULLY)**

7. Was the applicant under the influence of alcohol or narcotics when he/she became incapacitated? **(MUST BE ANSWERED FULLY)**

8. Was patient in the hospital? **(MUST BE ANSWERED FULLY)** YES NO FROM _____ TO _____

9. **IN MY OPINION, THE PATIENT WAS DISABLED AND UNABLE TO CONTINUE NORMAL ACTIVITY, DUE TO THE ILLNESS OR INJURY,**

FROM _____ **TO** _____ **(MUST BE ANSWERED FULLY)**
MONTH DAY YEAR MONTH DAY YEAR

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

PHYSICIAN'S STAMP REQUIRED

PHYSICIAN'S SIGNATURE _____

DATE _____

CITY AND STATE _____