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 *(RETIRED)*

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

MEMBER INFORMATION

FULL NAME		BIRTH DATE	TODAY'S DATE
ADDRESS	CITY	STATE	ZIP
HOME PHONE	CELL PHONE	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).

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 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.

In evidence of the claim of _____

(MEMBER'S NAME)

ATTENDING PHYSICIAN OR PRACTITIONER MAKING THIS REPORT IS REQUESTED TO ANSWER EVERY QUESTION ACCURATELY AND ADD SUCH OTHER INFORMATION AS MAY BE IN HIS OR HER POSSESSION 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	EMAIL ADDRESS		

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? ***(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 intoxicating drinks 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 ACTUALLY DISABLED AND UNABLE TO CONTINUE NORMAL ACTIVITY, DUE TO THE ILLNESS OR INJURY,**

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

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 _____

11242020