

NEW YORK STATE NURSES ASSOCIATION BENEFITS FUND

P.O. BOX 12-430 ALBANY, N.Y. 12212

LONG TERM DISABILITY CLAIM STATEMENT

NOTE: PLEASE FOLLOW THE FILING INSTRUCTIONS ON THE REVERSE SIDE OF THIS FORM.

TO BE COMPLETED BY THE PARTICIPANT:

PARTICIPANTS JOB TITLE		EMPLOYER	SOCIAL SECURITY NO.	
PARTICIPANTS NAME (Last)	(First)	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH Mo. Day Year	
ADDRESS (Street)		(City)	(State)	(Zip)

I CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT AND AUTHORIZE ANY PHYSICIAN, HOSPITAL, INSURANCE COMPANY OR ORGANIZATION TO PROVIDE PERTINENT RECORDS TO THE NEW YORK STATE NURSES ASSOCIATION BENEFITS FUND. A PHOTOSTAT OF THIS AUTHORIZATION SHALL BE VALID.

(Date)

(Participant's Signature)

TO BE COMPLETED BY THE PARTICIPATING EMPLOYER:

EMPLOYEE'S FULL NAME	DATE FIRST EMPLOYED
EMPLOYEE'S ADDRESS	LAST DAY WORKED
IF TERMINATED GIVE DATE AND REASON	WORK STATUS <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
COMPLETE POSITION TITLE	PRESENT MONTHLY BASE COMPENSATION \$
PREPARED BY (Title)	(Facility) (Date)

TO BE COMPLETED BY THE ATTENDING PHYSICIAN:

PATIENT'S FULL NAME	AGE	
DIAGNOSIS (Include Major Symptoms)		
ONSET DATE	DATE FIRST TREATED	DATE LAST TREATED
PATIENT WAS CONTINUOUSLY TOTALLY DISABLED FROM TO	PARTIALLY DISABLED FROM TO	PATIENT WAS, OR WILL BE ABLE TO RETURN TO WORK
ON: DEGREE OF RECOVERY: RECOVERED <input type="checkbox"/> IMPROVED <input type="checkbox"/> UNIMPROVED <input type="checkbox"/> RETROGRESSED <input type="checkbox"/> AMBULATORY <input type="checkbox"/> BED CONFINED <input type="checkbox"/> HOUSE CONFINED <input type="checkbox"/> HOSPITAL CONFINED <input type="checkbox"/>		
IF HOSPITALIZED GIVE HOSPITAL NAME	DATE ADMITTED	DATE DISCHARGED
NAME AND ADDRESS OF REFERRING PHYSICIAN (if any)		

Comments: _____

PHYSICIAN'S NAME (Print)	SIGNATURE	DEGREE		
ADDRESS (Street)	(City)	(State)	(Zip)	PHONE NO.
FOR PLAN USE ONLY	EFFECTIVE DATE(S) 1 - 2 -	CHECKED BY	DATE	