

For office use ONLY: Internal Claim #:

Date Received:

APPLICATION FOR BENEFITS (CLAIM FORM)

AMERICAN POSTAL WORKERS ACCIDENT BENEFIT ASSOCIATION

Box 120, Rochester, NH 03866 • (800) 526-2890 • APW-ABA.ORG

THIS CLAIM FORM MUST BE PROPERLY FILED WITHIN 90 DAYS AFTER THE DAY YOU RETURN TO WORK/NORMAL ACTIVITIES OR ARE RELEASED BY YOUR DOCTOR, WHICHEVER DATE OCCURS FIRST. IN INSTANCES OF A PROLONGED DISABILITY, THE CLAIMANT MAY FILE FOR BENEFITS NO SOONER THAN EVERY 30 DAYS. FAILURE TO PROPERLY FILL OUT THIS FORM OR PROVIDE SUPPORTING DOCUMENTATION WILL RESULT IN DENIAL OF YOUR CLAIM.

Name (Please Print): _____ Phone#: (____) _____

Check One: ABA Member Retired ABA Member Spouse of ABA Member

Local or State Organization: _____

I am unable to perform my duties as a _____

Example: Postal Employees: **Job Title** Spouse: **Employer and Job Title** Retiree: **Normal Life Functions**

- ✓ State fully how and by what means the accident happened and what injuries you sustained.
- ✓ If injury was due to a vehicle accident, submit copy of police/accident report.
- ✓ If injury was job related, submit copy of Workers' Compensation Claim Form, Form CA-1 (narrative section).
- ✓ Verification of time lost from work is required from your employer. **(Postal employees submit signed 3971's Time Card(s) or TAC rings.)**

1) I hereby certify that on Month _____ Day _____ Year _____

(State fully how and by what means the accident happened and what injuries you sustained.
If more room is needed, submit separate sheet.)

Note: THE AMERICAN POSTAL WORKERS ACCIDENT BENEFIT ASSOCIATION PAYS BENEFITS FOR DISABILITY OR DEATH RESULTING DIRECTLY AND EXCLUSIVELY FROM A COVERED ACCIDENT. LOSS OF TIME MUST BEGIN WITHIN 60 DAYS AFTER THE DATE OF THE ACCIDENT THAT CAUSED THE DISABILITY, UNLESS OTHERWISE JUSTIFIED BY MEDICAL EVIDENCE. REFER TO SUMMARY PLAN DESCRIPTION (SPD) FOR OTHER RESTRICTIONS.

2) Name of Physician treating you for this injury: _____

First Date Treated for this injury: Month _____ Day _____ Year _____.

Last Date Treated for this injury: Month _____ Day _____ Year _____.

3) Were you suffering from any sickness, disease, infirmity or previous accident at the time you received present injury?

(Describe in full) _____

4) I was totally disabled and unable to perform any type of duty (If Retiree: **Normal Life Functions**) as the result of an accident

for which I claim _____ days benefits beginning on Month _____ Day _____ Year _____

and terminating on Month _____ Day _____ Year _____.

5) On what date did you return to work? Month _____ Day _____ Year _____.

6) **CERTIFICATION IS REQUIRED (This section must be signed in order to process your claim.)**

By my signature below, I certify my statements and answers are true to the best of my knowledge; I have not concealed fact(s) which, if revealed, would invalidate my claim. I hereby grant authorization to any hospital, physician, or other provider who participated in my care and/or treatment, to release information to the APW-ABA which in their judgement they deem necessary to adjudicate this claim.

Signature	Date	Date of Birth	SS Number/EID
Mailing Address			@ E-mail Address

Signature of Local/State President or Designated ABA Representative (Retirees do not need to have this signed)

I have reviewed this claim and submit it to your office for consideration.

Signature	Date	Local/State
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STOP! CLAIMANTS ARE PROHIBITED FROM WRITING BELOW THIS LINE. **STOP!**

ATTENDING PHYSICIAN'S CERTIFICATION
Please fully answer all questions with as much detail as possible.

Name of Patient:

What is this patient's current primary disabling condition(s)? Please provide a detailed diagnosis.

Were said injuries the direct and sole result of an accident of external cause? Yes No

Are there secondary conditions contributing to the disability? Yes No

If yes, what are they and would the patient be disabled without regards to these secondary conditions?

List any test(s) performed and submit a copy of the results.

List any surgeries performed and submit a copy of the operative reports.

Restrictions (What the patient SHOULD NOT do)

Limitations (What the patient CANNOT do)

What is your prognosis of recovery?

How soon do you expect significant improvement in the patient's medical conditions? 1-2 months 3-4 months 5-6 months more than 6 months

Estimated Return to Work Date

Is this patient permanently disabled? Yes No

IF RETIREE: Is patient considered unable to perform their normal functions*? Yes No

IF RETIREE: Does the patient require assistance in performing their normal functions*? Yes No

**dressing, eating, transferring, toileting and meal preparation*

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Dates of Total Disability From: To:	Dates of Partial Disability From: To:	Patient's return to work date
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Dates of Office Visits (Last 3 months)

Dates of Hospitalization (Last 3 months)

Is patient currently being treated by another practitioner or therapist? If so, list name and address.

Name of Physician (please print)	Signature of Physician	Date
Physician's Phone Number ()	Physician's Fax Number ()	Tax ID or SSN
Physician's Address		