POLICE AND FIREMEN'S INSURANCE ASSOCIATION

101 East 116th Street • Carmel, IN 46032 • 800-221-7342 • www.pfia1913.org

BENEFITS REQUEST STATEMENT

Instructions: 1.) Complete **Side 1**. Have attending physician complete **Side 2**. 2.) Enclose itemized bills for any expense covered by policy and paid by you. Enclose all documentation that confirms your disability status. 3.) Any fees charged in filing this form must be paid by member. 4.) Failure to answer all questions fully may delay payment. 5.) Benefit period runs from date physician first consulted until date released to work. 6.) If claim for member's dependent, give claimant's name. Answer appropriate items. 7.) Dates of disability given by member and doctor must agree. Any changes made to **Side 2** statement must be initialed by doctor.
**** Total disability implies absolute physical incapacity to perform duties or work of any kind, resulting from sickness or injuries.***

Please answer all questions 1-11

Member's name________________________ Telephone # ____________

Member's address________________________ City, State ____________

Member's SSN # ____________ Date of birth ____________ Certificate/policy # ____________

Claimant's name ________________________ Claimant's SSN # ____________

1. (a) Primary occupation ____________ (b) Other occupations ____________
   (c) Name of employer________________________
   (d) Address of employer________________________
2. What sickness or injury was suffered?________________________
3. (a) Date first symptoms of sickness appeared ________________________
   (b) Date of accident ____________ (c) Date you last worked ____________
4. (a) How did the accident happen? Describe fully:________________________
   ____
   (b) Were you working at any job at the time of the accident? ❑ Yes ❑ No
5. (a) Date you first consulted a physician for this sickness or injury? (*Submit documentation from first doctor seen*)____________
   (b) Names and addresses of all doctors seen: ________________________
   ____
6. Have you ever had the same or similar sickness or disease before? ________ When? ____________
   Describe fully: ________________________
   ____
7. (a) Dates of total disability: from ____________, 20_____ to ____________, 20_____
   (b) Home confinement: from ____________, 20_____ to ____________, 20_____
   (c) Hospital confinement: from ____________, 20_____ to ____________, 20_____
8. Phone number of Human Resources/Administrative Services to verify duty status ____________
9. **Are you still disabled and unable to work at any job?** ❑ Yes ❑ No
10. **Have you returned to work in any capacity ?** ❑ Yes, regular duty ❑ Yes, modified/light duty ❑ No ____________
    If yes, indicate date
11. (a) Date disability commenced? ____________
    (b) Date returned to employment? ____________
    (c) Date released by physician? ____________

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. By signing this benefit request statement below, I affirm the truth and accuracy of all the information contained on Side 1 of the Benefits Request Statement. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. *This statement also applies to every other state serviced by PFIA.*

I authorize any physician or practitioner, hospital, medical related facility, insurance company or employer to give to Police and Firemen's Insurance Association [PFIA] any of the following about me: facts about my physical and mental health; any employment / attendance records; medical care, advice or treatment; and hobbies, insurance, flying, crimes and driving record. All such sources may give these facts to any insurance support organization which has been authorized by PFIA to collect and transmit them. This data will be used to find out if I am eligible for insurance. A photocopy shall be as valid as the original. It will be valid for thirty months from the date shown below.

Date ____________ Member's Signature ________________________

Form must be signed by ABM for your section:

The Relief Committee of Section no. ____________ together with the member of the Advisory Board recommends payment.

Date ____________ Agent # ________ ABM Signature ________________________

SIDE 2

To be completed by the attending physician

Any fees charged in filing this claim to be paid by claimant

Patient's name____ Age ____________

1. Diagnosis and concurrent conditions____

____

____

(a) If treatment for a fracture or dislocation: check the appropriate description.

❑ complete ❑ incomplete ❑ chip fracture ❑ dislocated ❑ open reduction ❑ closed reduction

(b) If treatment for laceration indicate length: ____

2. (a) When did symptoms first appear or accident happen?____

(b) When did patient first consult you for this condition?____

(c) Has patient ever had same or similar conditions? ____________ State when and describe:____________________

____

____

(d) Have you treated this patient for any other conditions affecting this claim? ____________________

Describe and give dates:____

____

____

3. Nature of any surgical procedure done:____

4. Give names and dates of any prior visits to another doctor or facility____

____

____

5. Give dates of medical treatment:____

6. Were x-rays taken? ❑ Yes ❑ No

7. Describe procedures, medical services or supplies furnished (accident claims):

____ Charges ____________________

____ Charges ____________________

____ Charges ____________________

8. (a) Dates of total disability: from ____________,20______ to ____________, 20______

(b) Home confinement: from ____________, 20______ to ____________, 20______

(c) Hospital confinement: from ____________, 20______ to ____________, 20______

9. **Has patient returned to work in any capacity ?** ❑ Yes, regular duty ❑ Yes, modified/light duty ❑ No ____________________ *If yes, indicate date*

10. (a) Date disability started? ____

(b) Date returned to employment ____

(c) Date released by physician ____

11. Is patient still under your care for this condition? ❑ Yes ❑ No

If no, please give discharge date ____

Remarks:____

____

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Any person who knowingly, and with intent to deceive or defraud, files a claim containing false, incomplete or misleading information may be in violation of state law. Use of the mail to defraud is a violation of federal law.

Date ____________________ Signature of attending physician____

Address ____

____

Telephone (include area code) ____