



POLICE AND FIREMEN'S INSURANCE ASSOCIATION

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

BENEFITS REQUEST - CONTINUOUS CLAIM

Please answer all questions 1-10

Total disability implies absolute physical incapacity to perform duties or work of any kind, resulting from sickness or injuries.

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 _____

2. What sickness or injury was suffered? _____

3. (a) Date first symptoms of sickness appeared _____ (b) OR date of accident _____

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. Are you still disabled and unable to work at any job? Yes No

9. Have you returned to work in any capacity? Yes, regular duty Yes, modified/light duty No

10. (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.***

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 _____

Member's name _____ Age _____

1. Diagnosis and concurrent conditions _____

(a) If treatment for a fracture or dislocation, indicate the location _____ and 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 name of referring physician, if any: _____

5. Give dates of medical treatment: _____

6. (a) Dates of total disability: from _____, 20____ to _____, 20____

(b) Home confinement: from _____, 20____ to _____, 20____

(c) Hospital confinement: from _____, 20____ to _____, 20____

7. Is patient still under your care for this condition? If no, give discharge date: _____

8. Date released to return to work in any capacity: _____ Regular duty Modified/light duty

Remarks: _____

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 _____

Degree

Address _____

Telephone (include area code) _____