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 ☐ M ☐ 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 ☐ Full Time ☐ 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 ☐ IMPROVED ☐ UNIMPROVED ☐ RETROGRESSED ☐; AMBULATORY ☐ BED CONFINED ☐ HOUSE CONFINED ☐ HOSPITAL CONFINED ☐

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

LTD-1 (12-81)