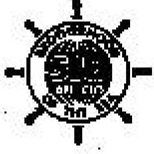

# SEAFARERS BENEFIT APPLICATION

## APPLICATION FOR: OPTICAL BENEFIT ● SICKNESS & ACCIDENT BENEFIT SEAFARERS PENSION ● DEATH BENEFIT ● SEAFARERS ALCOHOL AND DRUG ABUSE REHABILITATION BENEFIT

SEAFARERS HEALTH & BENEFITS PLAN, P.O. BOX 380, PINEY POINT, MD 20674

For information or help with this form, see your Port Agent or call: 1-800-252-4674

**To Be Completed by Member or Dependent**

1. Member's Name:_______________________________ S.S. No. ☐☐☐ ☐☐ ☐☐☐☐
   Full Given Name—PLEASE PRINT
   Address:_______________________________ Phone: (    )______________
   Street (Box/Apt.) City State Zip Area Code
2. Last or Present Employer:____________________ Vessel: ______________Rating: ______________

   Date you first worked for
   SIU/Inland Company:____________ Date Employment Terminated:____________ Book #: ______________
3. ELIGIBILITY: Attach proof of 120 days worked last year and 1 day worked in last six months. (Deep Sea provide discharges and Inland pro vide pay stubs. These must be attached for processing.)

| COMPANY | VESSEL | DATE ON | DATE OFF |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

4. Patient's Name:_______________________________ Sex: _________ Birth Date: ______________
   Month / Day / Year
   Address:_______________________________ S.S. No. ☐☐☐ ☐☐ ☐☐☐☐
   Relationship to Member:____________________ Have you submitted Marriage or Birth Certificate? yes ☐ no ☐
5. Have you filed previously for this claim? yes ☐ no ☐
6. Is patient covered by any other Medical Health Insurance? yes ☐ no ☐
   If yes, advise: Name of Insurance Carrier:____________________ Effective Date of Coverage: ____________
7. Is claim for an accident? yes ☐ no ☐
   How and where did it happen? _______________________________

_______________________________ Member or Dependent Signature

_______________ Date

## OPTICAL

**Enrollment card must be on file in Plan office along with Marriage Certificate and Birth Certificates, where applicable. Claim must be filed within 180 days from the date the glasses were received. Glasses are available to the member and dependents once in every two-year period from an optician of your choice.**

**To Be Completed by Optician**

Name of Optician:____________________________________ Optician Address: ____________________________________________
Street

_____________________________________________________________________________________________________________
City/State/Zip

Individual for whom prescribed: ______________________________________________________________________________

PLEASE ATTACH YOUR BILL TO THIS FORM AND INDICATE IF PAID yes ☐ no ☐

Total cost of glasses, including examination: $ ____________ Type of Lenses: Regular ☐ Clear ☐ Tinted ☐ Sunglasses ☐

SIGNATURE OF OPTICIAN:_____________________________________________ Optician's S.S. No. ___________________________

PLEASE SUBMIT AN ITEMIZED BILL INCLUDING THE DATE AND CHARGE OF EACH VISIT, THE DIAGNOSIS AND FEDERAL TAX IDENTIFICATION NUMBER. PLEASE INDICATE IF BILL HAS BEEN PAID.

**PLEASE SUBMIT ORIGINAL BILLINGS ONLY**

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## SICKNESS AND ACCIDENT BENEFIT

**Claim must be filed within 60 days (a) after discharge from hospital, or (b) from first day of outpatient disability. Outpatients who have not been hospitalized must be not fit for duty eight days before they can receive benefits, which are retroactive to the fifth day. You cannot receive S&A benefits if you are entitled to M&C from your employer, or to State disability benefits, or State unemployment benefits.**

**To Be Completed by Member**

Was illness or injury reported in Log Book? yes ☐ no ☐ Did you get Master's Certificate? yes ☐ no ☐

Were you hospitalized? yes ☐ no ☐ Hospital ____________________________________________________________

Date in: ____________ Date out: ____________ Address: ____________________________________________________________

Describe nature of illness: ____________________________________________________________________________

If accidental, attach doctor's letter on how the illness occurred. ______________________________________________________

Is this a recurring illness or injury? yes ☐ no ☐ If yes, explain:_______________________________________________

_____________________________________________________________________________________________________________

If you collected in-hospital benefits for this illness or injury, what was the last day you were paid? _______________________________

Have you applied for unemployment benefits? yes ☐ no ☐ Have you applied for State disability payments? yes ☐ no ☐

Have you taken up your injury with anyone else? yes ☐ no ☐ If yes, with whom? ____________________________________

What did they do? ____________________________________________________________________________________

I hereby certify that to the best of my knowledge, the above statements are true, and do also hereby authorize by attending physician(s) (Hospital or Clinic) to furnish and disclose all facts concerning my condition to the Seafarers Health & Benefits Plan.

Signature of Applicant:________________________________ Date ___________________ Verified by ___________________________

## PENSION

**ELIGIBILITY REQUIREMENTS –** CHECK CAREFULLY IN PENSION BOOKLET FOR EXACT TERMS**.**

| Check Pension desired: | Total Service Required | 125 days in calender year before application | Birth certificate or other proof of age required | Other required documents |
|---|---|---|---|---|
| ☐ NORMAL | 5,475 days | no | 65—Deep Sea<br>62–Inland | Submit all Coast Guard discharges, NFFD forms, and M&C forms, or Company service letter. |
| ☐ DEFERRED VESTED | 10 years of vesting service (125 days/yr) | no | 65–Deep Sea<br>62–Inland | Submit all Coast Guard discharges, NFFD forms, and M&C forms, or Company service letter. |
| ☐ EARLY NORMAL (Where applicable) | 7,300 days (Actual Employment) | yes | 55 | Submit all Coast Guard discharges covering seatime only. Boatmen submit Company service letter. |
| ☐ SPECIAL EARLY NORMAL | 7,300 days (Actual Employment) | no | 55 | 1) Withdrew completely from the industry before reaching age 55.<br>2) Submit all Coast Guard forms covering seatime only. Boatmen submit Company service letter. |
| ☐ SURVIVOR'S | Deceased was active member and eligible for one of the pensions above, not including disability pension.<br>Spouse's name:___________________________________ | | | S.S. No.____________________________ |
| ☐ DISABILITY Under 65 only<br>Date disability began _______________________________ | 4,380 days | yes | no | 1) Must submit permanently not fit for duty statement.<br>2) Must submit Social Security Disability Award or RRB B-6 certificate if under 65.<br>3) Must submit all Coast Guard discharges, NFFD forms, and M&C forms, or Company service letter. |

Name of Doctor: ____________________________________________________

Doctor's Address:__________________________________________________________________________________________

ATTACH A RECENT PHOTOGRAPH (PASSPORT SIZE) TO PENSION APPLICATION. If married, attach copy of your spouse's birth certificate, and a copy of your marriage certificate.

Verified by:____________________________________________ Date: __________________ Port: ________________________________
Union Representative