

SEAFARERS HEALTH AND BENEFITS PLAN45353 Saint Georges Avenue ■ Piney Point, MD 20674 ■ P: (800) 252-4674 (Option 3) ■ F: (301) 994-0116 ■ www.seafarers.org**SICKNESS & ACCIDENT BENEFIT APPLICATION**

This form is for an eligible participant in the Seafarers Health and Benefits Plan ("Plan") applying for an S&A benefit. Complete Sections 1 and 3 as they apply to you. Sections 2 and 4 must be completed by your treating physician. Section 5 of the form must be signed by you, your treating physician and an authorized SIU/Plan Representative. Complete and return the form by mail: SHBP Claims Department, Attn: S&A, 45353 Saint Georges Avenue, Piney Point, MD 20674

1 Participant's Information

Full Name (First, Middle Initial, Last)

XXX-XX-

Social Security Number

Date of Birth

Mailing Address

City

State

Zip Code

Cell Phone Number

Home Phone Number

Email

2 Treating Physician's Information

Medical Provider

Treating Physician's Name

Mailing Address

City

State

Zip Code

Office Phone Number

Fax Number

Email

3 Participant's Statement

1 When did your illness or injury first begin?

2 Did your illness or injury occur while working under covered employment on board a ship? Yes No

3 Were you hospitalized? Yes No

4 Describe the nature of your illness or injury:

5 Is this a recurring illness or injury? Yes, explain below No

6 Did you apply for Maintenance & Cure? Yes No

7 Did you apply for vacation payments through your Employer? Yes No

8 Did you apply for Workers' Compensation and/or State Disability Benefits, if offered in your state? Yes No

9 Did you apply for Social Security Disability Benefits? Yes No

10 Did you apply for Unemployment Benefits? Yes No

11 Have you applied for any other type of compensation for your current illness or injury? Yes, explain below No

12 Do you expect to receive any of the benefits listed in 6 - 10? Yes No

4 Treating Physician's Supplementary Statement

1 Patient Name:

2 Nature of illness or injury (describe complications, if any):

3 Did this illness or injury arise out of the patient's employment?

4 If due to an injury, please state the date of accident:

5 Date of first treatment: Date of most recent treatment:

6 When was the patient declared "Unfit for Duty" and unable to work?
From: To (actual date only):

7 When is the approximate date that the patient will be able to return to work?

THIS SECTION MUST BE SIGNED BY THE PARTICIPANT, TREATING PHYSICIAN, AND AN SIU/PLAN REPRESENTATIVE**5 Signature Authorizations**

I authorize my physician to release all my medical information concerning this illness or injury to the Seafarers Health and Benefits Plan. I certify that the above information is true and correct and I have provided this information with the understanding that the Plan will rely on the information for benefit

Participant's Signature

Date Signed

Treating Physician's Signature

Date Signed

Authorized SIU/Plan Representative's Signature

Date Signed