SEAFARERS HEALTH AND BENEFITS PLAN

45353 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 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