



**UNITED STATES LETTER CARRIERS MUTUAL BENEFIT ASSOCIATION**  
100 Indiana Avenue, N.W. Suite #510  
Washington, D.C 20001-2144  
(202) 638-4318

**IMPORTANT INFORMATION ABOUT FILING A DISABILITY CLAIM**

**PLEASE BE ADVISED ALL QUESTIONS MUST BE COMPLETED IN FULL TO AVOID DELAYS IN PROCESSING YOUR CLAIM**

**PHYSICIAN'S RECORDS – (IMPORTANT)**

All physician's medical records pertaining to your disability must be filed with each claim form. **Failure to provide this information may delay the processing of your claim.**

**PROOF OF LOSS**

Disability claim payments will only be made after written proof of loss is provided to our executive office. There will be no payments made for future dates of total disability. If you have any questions on any of the information provided on these sheets, please do not hesitate to contact our office at (202) 638-4318.

**ELIMINATION PERIOD**

Please be advised that you **must wait until after you have satisfied the ELIMINATION PERIOD** to have the claim form completed. If you have any questions regarding the Elimination Period for your claim, please refer to the SCHEDULE OF BENEFITS AND PREMIUMS page of your policy.

**AVOID DELAYS**

To avoid delays in the processing of your claim, **please review your claim to insure all of the questions have been fully answered.** All appropriate signatures and dates should be affixed to the claim form, The Insured must not complete any portion of the Physician's section or the Supervisor's section. MBA DOES NOT ACCEPT FAXED OR PHOTOCOPIED CLAIM FORMS.

**WAIVER OF PREMIUMS**

Remember that **until your disability claim has been approved, all premiums must be kept at a current status.** After satisfying the Elimination Period for your claim, any premium that you have paid while your total disability continues and the monthly benefit is being paid, will be refunded (see the **WAIVER OF PREMIUM** section of your policy).

**PROCESSING A CLAIM**

**Note that after all of the necessary information regarding a claim has been received by our office, the typical processing time for a claim is 2–3 weeks.** This time may vary depending on the number of claims we receive in our office.

**BENEFIT CHECK AMOUNTS**

**The actual amount of each benefit check may vary from your monthly indemnity amount.** Payment is based upon the dates for which our office has written verification that you met the requirements of TOTAL DISABILITY, as defined by your policy. This verification is provided to the MBA on the claim form by the signatures and dates of your physician and P.O. Supervisor.

**CONTINUING DISABILITY**

For continuing periods of disability, you will be required each month to submit a Supplementary Statement of Continuing Disability, until your claim has ended.

**WRITTEN PROOF OF LOSS**

**The disability Income Insurance policy requires you to give us written proof of loss,** unless it is not reasonably possible for you to do so, within 90 days after the end of each period for which we are liable, and it absolutely requires you to give us proof of loss within one year after the period for which we are liable unless you are legally incapacitated. Please review your policy, which sets out your and our rights and obligations.

# DISABILITY INCOME INSURANCE FORM

United States Letter Carriers

# MBA

Mutual Benefit Association

U.S. LETTER CARRIERS

MUTUAL BENEFIT ASSOCIATION

100 INDIANA AVENUE, N.W. SUITE #510

WASHINGTON, DC 20001

(202) 638-4318

Official Use Only

## PART "A" MEMBER'S STATEMENT

### A. MEMBER'S INFORMATION

- |                             |                                |
|-----------------------------|--------------------------------|
| 1. Name of Member _____     | Policy Number _____            |
| Address _____               | Telephone Number (____) _____  |
|                             | Social Security Number _____   |
| 2. NALC Branch Number _____ | Name of Branch President _____ |

**B. INSTRUCTIONS** This form is furnished to assist you in presenting a claim for benefits. Medical certification is required for the entire period you are disabled. Please follow the instructions below and be sure you, your physician, and your supervisor answer all questions on the form, sign and date it. If additional space is needed, attach a separate sheet of paper.

- I. This form **MUST** be completed **AFTER** the appropriate Elimination Period has been met.
- II. The three sections of this form must be completed in full by the appropriate person as follows:
  - 1. Part "A" by you (Member should not complete any information on Parts "B" and "C")
  - 2. Part "B" by your Physician (Medical records from the providers **MUST** be sent with this claim)
  - 3. Part "C" by your Employer (if more than one employer attach separate sheet(s) with information).
- III. All questions must be completed in full to avoid delays in processing your claim.
- IV. Please print or type clearly.
- V. Medical records from the providers **MUST** be sent with this claim.

**C. DEFINITION: ELIMINATION PERIOD** means the number of days, beginning with the day your total disability starts, for which no disability benefits are provided. It is shown in the Schedule of Benefits and Premiums Section of your policy. If you have questions concerning your elimination period call U.S. Letter Carriers Mutual Benefit Association, (202) 638-4318.

### D. TO BE COMPLETED BY THE MEMBER

#### AUTHORIZATION TO RELEASE INFORMATION

I authorize any licensed physician; medical practitioner; hospital; clinic or other medical or medically related facility; insurance company, including if applicable, the NALC Health Benefit Plan; government organization; Social Security Administration; other organization; institution or person that has any records or knowledge of me, my health (including any information relating to use of drugs or use of alcohol and any information relating to mental and physical history, condition, advice or treatment); earnings or other insurance benefits to release this information to the Mutual Benefit Association or it's duly authorized representatives.

I further understand that in executing this authorization, information obtained by it will be used for evaluating and administering a claim for benefits and that I have waived the right for such information to be privileged.

A Photostat copy of this authorization is to be considered as valid as the original and is effective for the duration of the claim. I certify that the information furnished by me in support of the claim is true and correct to the best of my knowledge and belief.

Several States require that this or a substantially similar statement appear on all claim forms:

The undersigned acknowledges that, any person knowingly and with intent to injure, defraud, or deceive any insurance company or other person, files a claim containing any materially false or deceptive information, or conceals for the purpose of misleading, information concerning any fact materially, thereto, commits a fraudulent insurance act which is a crime.

\_\_\_\_\_  
Claimant's Signature

\_\_\_\_\_  
Date

**PART "A" MEMBER**

- 1. Complete AFTER the appropriate elimination period has been met.
- 2. Complete ALL Sections of claim form

**E. INFORMATION ABOUT THE CONDITION CAUSING YOUR DISABILITY**

1. For **Illness, Injury, or Complication of Pregnancy**, answer the following questions:
  - a. What were your first symptoms \_\_\_\_\_
  - b. Date you first noticed symptoms \_\_\_\_\_ Date you were last treated by a physician \_\_\_\_\_
2. Have you had the same or similar condition(s) in the past?  YES  NO If yes, list condition(s) and date(s) of treatment \_\_\_\_\_  
\_\_\_\_\_
3. If any Injury, list date of accident, place and nature of accident \_\_\_\_\_  
\_\_\_\_\_

**F. INFORMATION ABOUT THE DISABILITY**

1. Is your condition related to your occupation?  YES  NO If yes, explain \_\_\_\_\_
2. Have you filed, or do intend to file a Worker's Compensation claim?  YES  NO If, yes date \_\_\_\_\_
3. **Have you returned to work?**  YES  NO If yes, **Part Time(date)** \_\_\_\_\_ **Full Time (date)** \_\_\_\_\_
4. If you have not returned to work, do you expect to?  YES  NO If yes, Part Time (date) \_\_\_\_\_ Full Time (date) \_\_\_\_\_
5. Have you retired from work?  YES  NO If yes, provide **Notification of Personnel Action (PS FORM 50)**

**G. INFORMATION ABOUT MEDICAL TREATMENT, PHYSICIANS, HOSPITALS AND TREATMENT CENTERS**

1. FIRST medical attention for the current disability was given by the following provider(s):
 

<u>Date</u>	<u>Name</u>	<u>Address</u>	<u>Telephone Number</u>
_____	_____	_____	( ) _____
_____	_____	_____	( ) _____
_____	_____	_____	( ) _____
2. List all other providers you have seen for this condition(s):
 

<u>Date</u>	<u>Name</u>	<u>Address</u>	<u>Telephone Number</u>
_____	_____	_____	( ) _____
_____	_____	_____	( ) _____
_____	_____	_____	( ) _____
3. Have you received treatment for the same or similar condition(s) in the past?  YES  NO If yes, list all Provides below:
 

<u>Date</u>	<u>Name</u>	<u>Address</u>	<u>Telephone Number</u>
_____	_____	_____	( ) _____
_____	_____	_____	( ) _____
_____	_____	_____	( ) _____

**H. OTHER EMPLOYMENT, GROUP HEALTH AND DISABILITY INSURANCE**

1. **Are you working at any other gainful occupation or job?**  YES  NO If yes, complete information below:  
 Name of Employer \_\_\_\_\_ Address \_\_\_\_\_  
 Immediate Supervisor's Name/Title \_\_\_\_\_ Telephone Number ( ) \_\_\_\_\_
2. List other Group Health and Disability Insurance
 

<u>Name</u>	<u>Address</u>	<u>Telephone Number</u>	<u>Type of Policy</u>
_____	_____	( ) _____	_____
_____	_____	( ) _____	_____
_____	_____	( ) _____	_____

**I. CLAIMANT'S SIGNATURE:**

I certify that the information furnished by me in support of this claim is true and correct to the best of my knowledge and belief.

\_\_\_\_\_  
Signature of Claimant

\_\_\_\_\_  
Date



**E. DOCTOR: Your opinion on the degree of disability is essential, therefore we ask that you, as the attending physician, personally sign this report. Your signature is certifying that the information furnished by you in support of this claim is true and correct to the best of your knowledge and belief.**

**Date** \_\_\_\_\_

Signature of Attending Physician (**NO stamp**) \_\_\_\_\_

Degree \_\_\_\_\_

Specialty \_\_\_\_\_

Attending Physician's Name (Print or Type) \_\_\_\_\_

Federal ID Number or Social Security Number \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_

Telephone ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

### **PART "C" EMPLOYEE'S SUPERVISOR**

1. Part C to be completed by the Employer ONLY.
2. Each Employer (Full or Part time) must complete a separate form.

### **A. GENERAL INFORMATION**

1. This claim is for (Employee's Name) \_\_\_\_\_ Social Security Number \_\_\_\_\_
2. Job Title \_\_\_\_\_ Are you the Primary Employer? \_\_\_ YES \_\_\_ NO
3. Date disability began \_\_\_\_\_ **First day claimant did not work because of disability** \_\_\_\_\_

### **B. INFORMATION ABOUT THE JOB AS IT RELATES TO THE DISABILITY**

1. Has the Claimant returned to any type of work? \_\_\_ YES \_\_\_ NO  
If yes, (a) performed **REGULAR DUTY** on (MM/DD/YYYY) \_\_\_\_\_  
(b) performed **LIGHT or LIMITED DUTY** on (MM/DD/YYYY) \_\_\_\_\_
2. Claimant has been released to return to **LIGHT DUTY WORK** but **LIGHT DUTY** is **NOT** available, explain \_\_\_\_\_
3. Has the claimant retired from work due to disability? \_\_\_ YES \_\_\_ NO If yes, provide **Notification of Personnel Action (PS FORM 50)**
4. Other comments you may wish to make relative to this disability claim \_\_\_\_\_

**C. EMPLOYER: The information concerning this disability is essential, therefore we ask that you as the employer personally complete and sign this report. I certify that the information furnished by me in support of his claim is true and correct to the best of my knowledge and belief.**

**Date:** \_\_\_\_\_

Signature of Supervisor (**NO Stamp**) \_\_\_\_\_

Title \_\_\_\_\_

Name of Supervisor (Print or Type) \_\_\_\_\_

Station or Unit Name \_\_\_\_\_

( ) \_\_\_\_\_  
Telephone Number