

**NAVAJO NATION EMPLOYEE BENEFIT PLAN**  
**PRELIMINARY STATEMENT OF DISABILITY-STD**

P.O. Box 2069  
 Cottonwood, AZ 86326

**THIS SECTION TO BE COMPLETED BY EMPLOYEE (Please Print)** Plan Number 710000

Full Name (Last, First, M.I.)		Social Security No.	Date of Birth
Mailing Address		Employer	Home Phone (      )
City		State	Zip
Occupation		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Type of Disability <input type="checkbox"/> Accident <input type="checkbox"/> Illness <input type="checkbox"/> Maternity

Describe how and where accident occurred or list symptoms of illness.

Is your injury or illness related to your work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date claim filed with Workers' Compensation Program
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Complete if your claim is for an accident:  Date accident occurred _____  How and Where? _____  Date symptoms first noticed _____  Date first treated _____	Complete if your claim is for an illness:  Date symptoms first noticed _____  Date first treated _____  List symptoms of illness _____  _____
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**If Workers' Compensation denied your claim, attach copies of denial letter, original claim filed, and Employee's Claim Petition**

I have been unable to work because of the disability since (m/d/yr):	<input type="checkbox"/> I returned to work Part Time on (m/d/yr)	<input type="checkbox"/> I returned to work Full Time on (m/d/yr)
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Date first treated for illness or injury	Doctor name and address	Hospital name and address
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Have you had same or similar conditions in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No	If so, when?	Doctor name and address	Hospital name and address
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**Describe any other income you are receiving or are eligible to receive as a result of your disability: (Examples: Social Security, Workers' Compensation, State Disability, Pension Disability, etc.)**

Describe Source	Amount of Income	Date Income Began	Date Income Ended

If your request for benefits is approved do you want us to withhold amounts from each benefit check for Federal Income Tax purpose?  Yes  No

If "yes", enter amount \$ \_\_\_\_\_  
 (Amount per week \$20.00 minimum) Signature \_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION- Must be signed and dated to validate the claim.**

To: Any licensed physician, medical practitioner, hospital, clinic, or other medical related facility, insurance company, employer, or consumer reporting agency.

(1) I authorize you to release the following to HMA, Inc., their reinsurers, or any consumer reporting agency on their behalf for purposes of determining disability benefits: full information, including copies of records, concerning medical examinations, history and treatment, occupation, income, and financial status.

(2) I have a right to receive a copy of this authorization upon request. A photocopy of this authorization shall be considered as valid as the original.

This authorization shall be valid for a period of one year from the date of signature.

DATE \_\_\_\_\_ SIGNATURE OF EMPLOYEE \_\_\_\_\_

**THIS SECTION TO BE COMPLETED BY EMPLOYER (Please Print)**

Employee's Name	Last Day Worked	Reason for Stopping Work	Date Returned Full Time	Date Returned Part Time
Date Hired	Occupation at Time of Disability	Work Schedule at Time of Disability Days/wk:                      Hrs/day:	Basic Annual Earnings as of Last Day Worked \$	
By any Employer-Employee, Labor Management, Union Welfare Plan or any State Disability, will (or has) Employee file(d) for Unemployment Compensation or for Disability provided? <input type="checkbox"/> Yes <input type="checkbox"/> No                      If yes, please specify:			Is Employee eligible for Workers' Compensation? Amount \$                      Carrier <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employer Address				
Telephone	Title	Date	Signature	

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION, CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

**ATTENDING PHYSICIAN'S STATEMENT OF ACCIDENT OR ILLNESS**

1. Patient's Name	Date of Birth
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2. Nature of injury or illness (Describe complications, if any):

3. When did accident happen or symptoms first appear? (m/d/yr)	4. When did patient first consult you for this condition? (m/d/yr)
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5. Is condition due to injury or sickness arising out of patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, explain:	6. Has patient ever had same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, state when and describe:
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7. Describe any other disease or infirmity affecting present condition:

8. Date and nature of surgical or obstetrical procedure, if any. Describe fully:

9. Give dates of treatment:  OFFICE _____ HOME _____ HOSPITAL _____	10. If patient is hospitalized give name and address: HOSPITAL _____ ADDRESS _____ CITY, STATE, ZIP _____ Date admitted _____   Date Discharged _____
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11. How long was or will patient be continuously totally disabled. (Unable to work)? From _____ 20____ Through _____ 20____	12. How long was or will patient be partially disabled? From _____ 20____ Through _____ 20____
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13. If due to pregnancy:  LMP Date _____ EDC Date _____  Date Delivered: _____ Complications, if any:	14. Is this patient competent to endorse checks and direct the proceeds with a clear understanding of the nature of his/her acts? Comments. <input type="checkbox"/> Yes <input type="checkbox"/> No
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(\*As defined in Federal Dictionary of Occupational Titles)

Class 1 - No limitation on functional capacity; capable of heavy work\* No Restrictions. (0-10%)

Class 2 - Medium manual activity\* (15-30%)

Class 3 - Slight limitation of functional capacity; capable of light work\* (35-55%)

Class 4 - Moderate limitation of functional capacity, capable of clerical/administrative (sedentary\*) activity. (60-70%)

Class 5 - Severe limitation or functional capacity; incapable of minimum (sedentary\*) activity (75-100%)

REMARKS:

Attending Physician's Name (Please Print)	Degree
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Mailing Address	City	State	Zip
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Telephone (   )	Date	Signature
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