AMERICAN POSTAL WORKERS
APW · ABA
ACCIDENT BENEFIT ASSOCIATION

American Postal Workers
Accident Benefit Association
PO Box 120
Rochester, NH 03866
(800) 526-2890
APW-ABA.ORG

CLAIM FOR DISABILITY BENEFITS

The American Postal Workers Accident Benefit Association pays benefits for disability resulting directly and exclusively from a covered accident. Loss of Time must begin within 60 days after the date of the accident that caused the disability, unless otherwise justified by medical evidence. Refer to Summary Plan Description (SPD) for other restrictions.

This form must be completed by the Claimant and the Attending Physician, and be returned within 90 days after the day you return to work/normal daily life functions or are released by your doctor, whichever date occurs first. In instances of a prolonged disability, the claimant may file for benefits no sooner than every 30 days.

All questions on this form must be answered in full. Incomplete or illegible answers may result in denial of benefits. **All signatures on this form must be original.** Copies of signatures will result in denial of benefits. **WE DO NOT ACCEPT OR PROCESS FAXED OR EMAILED CLAIMS.**

The claimant is responsible for completion of all portions of this form without expense to the American Postal Workers Accident Benefit Association. Please be sure to keep a copy of this form and any attachments for your records. **Please be advised, if you have not returned to work/normal daily life functions or been released by your doctor you will only be compensated to the date that doctor signs the form and you will be required to repeat this process.**

INSTRUCTIONS:

Claimant's Statement: This section must be completed by you, the claimant.

- State fully how and by what means the accident happened and what injuries you sustained.
- If injury was due to a vehicle accident, submit copy of police/accident report.
- If injury was job related, submit a complete copy of Workers' Compensation Claim Form, Form CA-1 (including the Supervisor's statement).
- Verification of time lost from work **is required** from your employer. **(Postal employees submit signed 3972's or TAC rings)**.

Please make sure you sign and date the bottom of the authorization page after you complete your section. Enclose any additional information that you feel will assist us in evaluating this claim. ***All signatures on this form must be original.***

Attending Physician's Statement: This section must be completed by the physician PRIMARILY responsible for your care. Please make sure all dates of disability and treatment are indicated in this section and that your physician personally signs and dates this claim form. Please be advised, if you have not returned to work/normal daily life functions or been released by your doctor you will only be compensated to the date that doctor signs the form and you will be required to repeat the process. **All signatures on this form must be original.**

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DIRECT DEPOSIT OF CLAIMS PAYMENT

If you would like your claim payment directly deposited into your checking or savings account, please complete the following information. Please be advised, once payment is made it can take up to 72 hours to appear in your account.

Member's Authorization for Direct Deposit

I authorize the American Postal Workers Accident Benefit Association and the financial institution listed below to initiate electronic credit entries, and if necessary, debit entries for any credit entries I have received in error to my:

_____ Checking Account _____ Savings Account

This authority will remain in effect for the length of this claim unless cancelled in writing.

_____
Member's Name (Please print)

_____
SS# or Employee ID #

_____
Member's signature

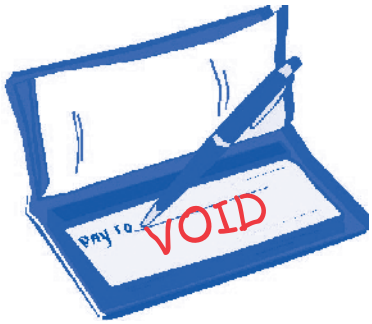
_____
Date

_____
Member's e-mail address

_____
Financial Institution (Bank Name)

Transit/Routing # _ _ _ _ - _ _ _ _ - _ Account # _____

Please return this form to our office along with a voided check*



**** If you would like us to credit your savings account, check with your local bank to ensure you have provided us with the correct Transit (Routing) number and correct account number. If a check is returned to us because of an incorrect savings account number you provided, you are responsible to reimburse the ABA any and all fees charged by its bank.***

For office use ONLY: Internal Claim #_____ Date Received:_____

APPLICATION FOR BENEFITS (CLAIM FORM)

AMERICAN POSTAL WORKERS ACCIDENT BENEFIT ASSOCIATION
Box 120, Rochester, NH 03866 (800) 526-2890 APW-ABA.ORG

CLAIMANT'S STATEMENT

Name (Please Print)

Check One: ABA Member ☐ Retired ABA Member ☐ Spouse of ABA Member ☐

Local or State Organization:

Home Address (Street, City, State, Zip):

Phone Number: ( ) Date of Birth: SS# / EID:

E-mail Address: @

I am unable to perform my duties as a _____
Example: **Postal Employees: Job Title** **Spouse: Employer and Job Title** **Retiree: Normal Life Functions**

I hereby certify that on Month _____ Day _____Year _____ _____

_____

_____
(State fully how and by what means the accident happened and what injuries you sustained. If more room is needed, submit separate sheet.)

Name of Physician treating you for this injury: _____

First Date Treated for this injury: Month _____ Day _____ Year _____.

Last Date Treated for this injury: Month _____ Day _____ Year _____.

Were you suffering from any sickness, disease, infirmity or previous accident at the time you received present injury?
(Describe in full)

I was totally disabled and unable to perform any type of duty (If Retiree: Normal Life Function(s)) as the result of an accident for which

I claim _____ days benefits beginning on: Month _____ Day _____ Year _____

and terminating on: Month _____ Day _____ Year _____.

On what date did you return to work? Month _____ Day _____ Year _____.

CERTIFICATION IS REQUIRED (This section must be signed in order to process your claim)

By my signature below: I certify my statements and answers are true to the best of my knowledge; I have not concealed fact(s) which if revealed, would invalidate my claim. I hereby grant authorization to any hospital, physician, or other provider who participated in my care and/or treatment, to release information to the APW-ABA which in their judgment they deem necessary to adjudicate this claim.

_____ _____
Signature **Date**

ONLY ORIGINAL SIGNATURES WILL BE ACCEPTED
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ATTENDING PHYSICIAN'S CERTIFICATION

STOP! **CLAIMANTS ARE PROHIBITED FROM WRITING BELOW THIS LINE.** ***STOP!***

Physician: Please fully answer all questions with as much detail as possible.

Name of Patient:

Please provide a detailed diagnosis of patient's injuries.

Were the above injuries the direct and sole result of an accident of external cause? Yes ☐ No ☐

Are there secondary conditions contributing to the disability? Yes ☐ No ☐

If yes, what are they? _____

Would the patient be disabled without regards to these secondary conditions? Yes ☐ No ☐

List all test(s) performed and **provide a copy of the results**.

List all surgeries performed and **provide a copy of the results**.

Restrictions (What the patient SHOULD NOT do)

Limitations (What the patient CANNOT do)

What is your prognosis of recovery?

How soon do you expect significant improvement in the patient's medical conditions?

☐ 1-2 months ☐ 3-4 months ☐ 5-6 months ☐ more than 6 months

Estimated Return to Work Date/IF RETIREE: Normal Daily Life Functions

Is this patient permanently disabled? Yes ☐ No ☐

IF RETIREE: Is patient considered unable to perform their normal daily life functions? Yes ☐ No ☐

IF RETIREE: Does the patient require assistance in performing their normal daily life functions? Yes ☐ No ☐

Dates of Total Disability (UNABLE TO WORK ANY TYPE OF DUTY) (IF RETIREE: UNABLE TO PERFORM NORMAL DAILY FUNCTIONS)	**Dates of Partial Disability** Able to work: ☐ light ☐ limited ☐ sedentary/duty	**Patient's return to work date:**
From: To:	From: To:	**IF RETIREE: Patient's release to Normal Daily Life Functions:**

Dates of Office Visits	Dates of Hospitalization

Is patient currently being treated by another practitioner or therapist? If so, list name and address.

Name of Physician (please print)	Signature of Physician	Date
Physician's Phone Number ( )	Physician's Fax Number ( )	Tax ID or SSN

Physician's Address (Street, City, State, Zip)

ONLY ORIGINAL SIGNATURES WILL BE ACCEPTED

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