MASTERS, MATES AND PILOTS HEALTH AND BENEFIT PLAN
700 Maritime Blvd. Suite A
Linthicum Heights, Maryland 21090-1996

STATEMENT OF CLAIM FOR
WEEKLY DISABILITY BENEFITS

Have all questions been answered?

Is your Social Security Number Correct?

PART A — EMPLOYEE STATEMENT

Your Name (Last / First / Middle Initial)	Your Soc. Sec. #

Home Address (Street / City)	State	Zip	Your Telephone No.

Name of Employer	Last Voyage From ____ To ____
First Day of Disability	Date You Returned To Work

Were You Injured on The job? Yes ☐ No ☐ If Yes, Give Date Injured

Were You Hospitalized Yes ☐ No ☐ Name of Hospital

Confined From To

Did You See a Doctor? Yes ☐ No ☐ Describe Your Disability

UNEARNED WAGES YES ☐ NO ☐ FROM _____ TO _____

I AM ENTITLED TO UNEARNED WAGES YES ☐ NO ☐

DISABILITY BENEFITS CANNOT BE PAID WHEN AN EMPLOYEE IS ENTITLED TO RECEIVE UNEARNED WAGES AND ACCEPTS THEM OR IF HE IS ON THE PAYROLL OF AN EMPLOYER.

I REQUEST WEEKLY DISABILITY/DAILY HOSPITAL BENEFITS FOR MY DISABILITY. I UNDERSTAND THE FOLLOWING CONDITIONS APPLY A) BENEFITS OF $50.00 PER WEEK FOR A MAXIMUM OF 13 WEEKS IS PAYABLE FOR EACH PERIOD OF DISABILITY B) BENEFITS WILL BE PAID UPON SUBMISSION OF PROOF OF DISABILITY (DUTY STATUS SLIP) AND UP TO THE DATE THE PHYSICIAN COMPLETED THE STATEMENT VERIFYING MY UNFIT FOR DUTY STATUS.

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I HEREBY AUTHORIZE ANY PHYSICIAN, HOSPITAL, MEDICAL CLINIC, INSURANCE COMPANY, EMPLOYER OR OTHER FACILITY TO FURNISH AND DISCLOSE ALL KNOWN FACTS CONCERNING THIS DISABILITY TO THE MM & P HEALTH AND BENEFIT PLAN. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

_____ DATE

_____ EMPLOYEE'S SIGNATURE

PART B — PHYSICIAN STATEMENT

Patient's Name (Last / First / Middle Initial)	Give dates and Diagnosis of Treatment

The Patient has been continuously disabled (unable to work) FROM ____ THRU ____	If Patient still disabled, give estimated date Patient will be able to resume work.

Did your doctor complete **all** questions?

Was Patient Hospitalized? ☐ YES ☐ NO	FROM / THRU	Was Patient Injured on the Job? ☐ YES ☐ NO

Signed _____ (PHYSICIAN) Date Signed _____

(PRINT OR TYPE PHYSICIAN'S NAME) (DEGREE) PHONE

Address _____ CITY STATE ZIP CODE