



TEXAS POLICE TRUST
 1600 State Street
 Houston, Texas 77007
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DIS N0071947A

APPLICATION FOR DISABILITY BENEFITS
(To Avoid Delay Please Answer All Questions)

PART I – CLAIMANT’S REPORT

| | | | | | | | | | |
|---|--|---------------------------|----------------------|------------------------|---------------------------------|----------------------------------|--|-----------|--|
| 1. FULL NAME (LAST, FIRST, MIDDLE) | | 2. SOCIAL SECUTIRY NUMBER | | 3. GENDER __ M __ F | | 4. BIRTHDAY __/__/__ | | 5. E-MAIL | |
| 6. ADDRESS | | | CITY, STATE ZIP CODE | | | BEST CONTACT PHONE NUMBER | | | |
| 7. OCCUPATION | | | 8. DATE OF ACCIDENT | | | 9. PLACE WHERE ACCIDENT OCCURRED | | | |
| 10. NATURE OF INJURY (INDICATE PART OF BODY INJURED-e.g. BROKEN ARM, SPRAINED ANKLE, ETC.) | | | | | | | | | |
| 11. DESCRIBE HOW ACCIDENT OCCURRED (INDICATE COMPLETE DETAILS OF THIS INCIDENT) | | | | | | | | | |
| 12. DATE YOU WERE FIRST TREATED FOR THIS INJURY | | | | | 13. NAME & ADDRESS OF PHYSICIAN | | | | |
| 14. HAVE YOU EVER HAS SAME OR SIMILAR CONDITION? __ YES __ NO | | | | | 15. NAME & ADDRESS OF PHYSICIAN | | | | |

I, hereby authorize any hospital, physician, or other person who has examined or attended me to disclose when requested to do so, all information with respect to any injury, treatment, policy coverages, medical history, consultations or prescriptions, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE _____ DATE _____

PART II – SUPERVISOR’S STATEMENT

| | | | | | | | |
|---|--|-----------------------------------|--|---------------------------|--|--------------------|--|
| 1. LAST DAY WORKED | | 2. OCCUPATION (AT TIME OF INJURY) | | 3. BASIC MONTHLY EARNINGS | | 4. MONTHLY BENEFIT | |
| 5. DID ACCIDENT OCCUR DURING A POLICYHOLDER SPONSORED & SUPERVISED ACTIVITY? __ YES __ NO | | | | | | | |

 SIGNATURE OF POLICYHOLDER REPRESENTATIVE

 TITLE

 DATE

PART III – ATTENDING PHYSICIAN’S STATEMENT

| | | | | | |
|---|--|--|--|--|--|
| 1. DIAGNOSIS AND CONCURRENT CONDITIONS Use ICD-9 code(s) or give name(s) | | | 2. IS THIS CONDITION DUE TO INJURY ARISING OUT OF PATIENT’S EMPLOYMENT? __ YES __ NO | | |
| 3. DATE SYMPTONS FIRST APPEARED: | | | 4. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION: | | |
| 5. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? __ YES __ NO (If “YES”, when & describe) | | | | | |
| 6. NAME, ADDRESS, & BEST CONTACT NUMBER OF REFERRING PHYSICIAN: | | | | | |
| 7. IS PATIENT TOTALLY DISABLED (UNABLE TO WORK)? If so, indicate the date(s) the patient is totally disabled FROM: THROUGH: | | | 8. IS PATIENT PARTIALLY DISABLED? If so, indicate the date(s) the patient is partially disabled FROM: THROUGH: | | |
| 9. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK: | | | 10. Is Patient Still Under Your Care for this Condition? __ YES __ NO | | |
| 11. PHYSICIANS BEST CONTACT PHONE and FAX NUMBERS (Include Area Code) and EMAIL ADDRESS | | | | | |
| 12. PHYSICIANS ADDRESS (Street, City, State, Zip) | | | | | |

 PHYSICIAN'S SIGNATURE

 PHYSICIAN NAME PRINTED

 DATE