



AMERICAN MARITIME OFFICERS (AMO) PLANS

2 West Dixie Highway, Dania Beach, FL 33004
 Tel: (954) 920-4247 (800) 348-6515 Fax: (954) 920-9482 www.amoplans.com

For AMO Official Use Only

Received Date: _____

Received By: _____

APPLICATION FOR SICKNESS AND ACCIDENT DISABILITY BENEFIT

When a physical or mental disability makes an active participant unfit to perform their normal duties, and requires regular care and attendance of a legally qualified physician, the Plan provides a weekly benefit as provided by your particular group coverage.

Instructions:

1. Complete the front side of this application for Sickness and Accident Disability Benefit form.
2. The active participant must submit to reasonable examinations as required by the Trustees to determine disability.
3. The attending legally qualified physician must complete the reverse side of this form indicating the extent of the disability.
4. To claim disability benefits, the completed form should be submitted to the AMO Medical Plan office for benefit determination.

Important Information:

1. Disability payments will be made no more frequently than at seven (7) day intervals.
2. There is a waiting period for each disability of one (1) day after the date of an injury or eight (8) consecutive days from the date of the illness. There will be no waiting period from the date of hospital confinement.
3. No benefits or credit for a waiting period will be given for any period during which the active participant is on the payroll of the employer, including earned wages, vacation, sick leave (if contributions are made to the Plan,) unearned wages (if contributions are made to the Plan,) or family leave (Great Lakes only.)
4. The Plan will offset disability payments by Disability or Worker's Compensation under the laws of any state, maintenance and cure as required by maritime law, unearned wages (if no contributions are made to the Plan), or sick leave (if no contributions are made to the Plan). The offset payments will be treated as Disability Credit Days. The participant will be required to refund the AMO Medical Plan in the event contributions are received for a period of covered employment during which disability benefits have been paid.
5. Where an active participant who is eligible for benefits under the AMO Medical Plan is disabled while working on a vessel not signatory to the Plan, no disability benefits are payable under the AMO Medical Plan.
6. A participant who received a disability benefit under this Plan and who after returning to work is again determined to be disabled with a similar diagnosis within a period of 182 days from the last day of the previous disability, will be eligible for additional benefits not to exceed the maximum benefit provided under the particular group's coverage for the total accumulated disability period.
7. The term "legally qualified physician" for declaring a participant disabled shall mean only a person who is duly licensed to prescribe and administer any and all drugs.

TO BE COMPLETED BY ACTIVE PARTICIPANT ONLY

PARTICIPANT INFORMATION

Applicant's Name:		SSN: XXX-XX-	
Street Address:			
City:		State:	ZIP Code:
Home Telephone No.:		Cell Phone No.:	
If illness or injury resulted during the course of employment, please complete the following:			
Company Name:		Vessel:	Rating:
Applicant's Actual Date of Employment Prior to Disability:		Period of Disability Being Claimed:	
From: (Date) To: (Date)		From: (Date) To: (Date)	

DISABILITY INFORMATION

Related to your present disability, are you receiving or claiming:

Type of Payment	Period of Payment From: To:	Expected Duration of Payment From: To:	Remarks
Earned Wages			
Unearned Wages			Is your employer contributing for your benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No
Sick Leave			
Family Leave (Great Lakes)			
Maintenance & Cure			
Have you since been employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is the disability the result of an injury or illness arising out of or in the course of employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you eligible for any state of federal unemployment benefits for the period covered by this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Have you received disability benefits for another period or periods? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please explain:	

SIGNATURE

I hereby certify that the information contained herein is true. I understand that if I make a false statement and collect money fraudulently from the American Maritime Officers Medical Plan, my eligibility for medical benefits will. Terminate, and I am liable to expulsion form the union in accordance with the terms of the constitution.

Signature of Participant:

Date:

PHYSICIAN'S STATEMENT
(to be completed by a legally qualified physician)

Claimant's Name:	Claimant's Age:
Claimant's Diagnosis:	
Claimant's Symptoms:	
Objective Findings:	
Was patient hospitalized for this period of disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, dates of hospital confinement: (From/ To)
Was the patient operated on: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, type of operation: _____ Date of operation: (From/ To)

DIAGNOSIS AND HISTORY

	MONTH	DAY	YEAR
Date of your first treatment for this period of			
Date of your most recent treatment for this disability			
Date claimant was unable to work because of this disability			
Date claimant will be able to perform usual work			
Date claimant can perform any other work			
Remarks:			

SIGNATURES

Physician's Name: (must be MD or DO)			
Street Address:	City:	State:	ZIP Code:
Phone Number:	Federal I.D. Number:		
Physician's Signature:			Date:

**** PLEASE ATTACH ANY MEDICAL RECORDS OR DOCUMENTATION IF PERTINENT ****