



AMERICAN MARITIME OFFICERS (AMO) PLANS

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For AMO Official Use Only

Received Date: _____

Received By: _____

CLAIM FOR TOTAL AND PERMANENT DISABILITY

PATIENT INFORMATION

1. Patient Name:		DOB:	
2. Street Address:			
City:		State:	ZIP Code:
3. Telephone Number:		Date of Disability:	
Disability Diagnosis:		4. Has a disability application been filed with Social Security? <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Has your disability been approved or denied? <input type="checkbox"/> Yes <input type="checkbox"/> No		6. If denied, has an appeal been made? <input type="checkbox"/> Approved <input type="checkbox"/> Denied	
7. If denied, has an appeal been made? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Appeal:	
Patient Signature:		Date:	
Signature of Claimant's Power of Attorney:		Date:	
(Please submit the official documentation that provides you with Power of Attorney)			

TO BE COMPLETED BY ATTENDING PHYSICIAN (PLEASE ANSWER QUESTIONS (8-19))

8. In your medical opinion, will the patient be able to return to his/ her current employment as an Officer in the Maritime Industry? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please indicate date: (mm/dd/yyyy)		
9. In your medical opinion, will the patient be able to be gainfully employed in any other type of employment? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please indicate date: (mm/dd/yyyy)		
10. Please indicate the first date on which you began treatment of this patient for disability:	11. Has this disability been continuous? <input type="checkbox"/> Yes <input type="checkbox"/> No	
12. In what way is the patient disabled? Please describe any limitations:		
13. Is treatment for the disability currently being provided? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe treatment:		
14. What is patient's response to the treatment:		
15. Was the patient confined in a hospital during any period of this disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, for how long:	
16. Is the patient currently confined in a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No		
17. Please supply the dates and detailed findings of the most recent. Please note: In order to process this disability claim, all pertinent and current medical records must be submitted with this claim form.		
Medical Examination	Dates:	Details:
X-Ray:	Dates:	Details:
Electrocardiogram:	Dates:	Details:
Lab Tests:	Dates:	Details:
MRI:	Dates:	Details:
Other (please specify) _____	Dates:	Details:
18. Is the patient mentally capable of transacting his/her personal affairs, such as endorsing checks, and consciously aware of the nature of and consequences of his/her acts? <input type="checkbox"/> Yes <input type="checkbox"/> No		
19. Additional Remarks:		

PHYSICIAN'S SIGNATURE

Signature:		Date:	
Name:		Telephone Number:	
State License Number:		Tax I.D. Number:	
Address:	City:	State:	ZIP Code: