

AMERICAN MARITIME OFFICERS PLANS

MEDICAL – PENSION – MONEY PURCHASE BENEFIT – VACATION – SAFETY & EDUCATION – 401(k)

2 West Dixie Highway, Dania Beach, FL 33004-4312
Telephone (954) 920-4247 or (800) 348-6515 Fax (954) 922-7539 www.amoplans.com

CLAIM FOR TOTAL AND PERMANENT DISABILITY

1. Patient's Name: _____ Telephone Number: _____
 2. Patient's Present Address: _____
Number and Street City State Zip Code
 3. Date of Birth: _____ Date of Disability: _____ Disability Diagnosis: _____
 4. Has a disability application been filed with Social Security? Yes No
 5. Has your disability been approved or denied? Approved Denied
 6. If denied, has an appeal been made? Yes No Date of Appeal: _____
- Signature of Claimant: _____ Date: _____
- Signature of Claimant's Power of Attorney (If applicable): _____ Date: _____
(Please submit the official documentation that provides you with Power of Attorney)

TO BE COMPLETED BY ATTENDING PHYSICIAN – PLEASE ANSWER QUESTIONS 7 -18

7. In your medical opinion, will the patient be able to return to his/her current employment as an Officer in the Maritime Industry? Yes No If yes, please indicate date _____
8. In your medical opinion, will the patient be able to be gainfully employed in any other type of employment? Yes No If yes, please indicate date: _____
9. Please indicate the first date on which you began treatment of this patient for disability: _____
10. Has this disability been continuous? Yes No
11. In what way is the patient disabled, please describe any limitations: _____

12. Is treatment for the disability currently being provided? Yes No
If yes, describe treatment: _____

13. What is patient's response to the treatment? _____

14. Was the patient confined in a hospital during any period of this disability? Yes No
 If yes, for how long: _____
15. Is the patient currently confined in a hospital? Yes No

16. 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)

- (A) Medical examination: _____
- (B) X-Ray: _____
- (C) Electrocardiogram: _____
- (D) Lab Tests: _____
- (E) MRI: _____
- (F) Other (specify): _____

17. Is the patient mentally capable of transacting his/her personal affairs, such as endorsing checks, and consciously aware of the nature and consequences of his/her acts? Yes No

18. **Additional Remarks:**

PHYSICIAN'S SIGNATURE	Print Name Here	Date
State License Number: _____ Tax I.D. Number: _____		
Address: _____		
Number and Street	City	State
		Zip Code
Physician Telephone Number: _____		

Please forward completed claim form and medical records to the AMO Pension Plan at the address above. Thank you.

FOR INTERNAL USE ONLY:

Disability Approved: _____ Disability Denied: _____ Date: _____