M.S.E.A INCOME PROTECTION PLAN & TRUST

5 Community Drive, Augusta, Maine 04330
(207) 622-3151 / (207) 621-1475 (FAX)

PRELIMINARY STATEMENT OF DISABILITY

Section 1 – Employee Information – Please Print Clearly

Name:____________________ Social Security #: ________________
Mailing Address:____________________City:__________State:_____Zip:_____
Date of Birth:________Phone #: (H)________(W)_______E-Mail____________
Last Date Worked:__________ Dept:________ Occupation:____________
Date Injury/Illness Began:__________ Date of First Medical Treatment: __________
Name/Phone of Medical/Mental Health Provider: ________________________
Describe Injury/Illness: ______________________________
If injury, please explain where, when, and how you were injured: ____________________
Have you filed a Worker's Compensation claim for this condition?_____Yes ____No
Have you ever served in the Military?_____Yes ____No

I hereby certify that I have answered all questions truthfully and to the best of my knowledge. I have signed the medical release and subrogation agreements on the reverse side of this form.

Employee Signature:____________________ Date: ____________

Section 2 – Attending Medical/Mental Health Provider Statement

Diagnosis (Include ICD 10 Codes): ____________________________
____
List Surgical Procedures, if any: ____________________________
If pregnancy, please give Estimated Date of Delivery:___/___/___
Date Injury/Illness Occurred:___/___/___ Date Patient First Consulted You:___/___/___
Dates of Treatment: (Office)____________________(Hospital)____________
Is Patient Totally Disabled** from Performing Their Job?_____Yes ____No
Is Condition Due to Patient's Employment? ____Yes ____No
Is Patient Still Under Your Care for Condition? ____Yes ____No Date of Next Appt:___/___/___
Dates of Continuous Total Disability: From___/____/__Through_____/___/___*
* If unknown at this time, please estimate approximate length of disability period ________________

**A member is totally disabled if they are deemed unable to perform any and all of the usual duties of their occupation due to a non-occupational illness or accidental injury, in a temporary or permanent capacity.

Please type or print

Provider's Name:____________________ Telephone #: ____________
Address:____________________City__________State______Zip ______
Provider's Signature:____________________ Date: ____________

Section 3 – MSEA Income Protection Plan – Office Use Only

Department:______________ Social Security #:______________ Payroll:____________
Date Employed:____________ Date Joined IP:____________ Open Enrollment?______Yes ____No
Eff Date of Last Change:____________Monthly Benefit: $____________OE Inc?______Yes ____No

IPPT Personnel Signature____________________ Date: __________

**Please return the completed form to the MSEA Income Protection Plan at the address above.
Incomplete forms will be returned for completion and will delay processing of benefits.**

NAME:________________________________ Soc Sec #: _________________________

Release of Information

I authorize the MSEA Income Protection Plan & Trust or its designees, all health providers, third party payers, utilization review agencies, my employer, my attorney, and state or federal agencies to exchange all demographic, medical, mental health, AIDS and HIV, and substance abuse information necessary for claims processing, clinical studies, care management, plan administration, benefit determination or resolution of subrogation and workers' compensation issues. I understand any such information will be used only after issuance of coverage and will have no effect on determination of eligibility to enroll.

I give this consent for myself and my successors, heirs and assigns. (I understand that failure to sign this unmodified authorization may be basis for benefit denial.) I understand I am entitled to receive a copy of this authorization. I further understand that this authorization will remain in effect until coverage under this plan ends or I give written notice to the MSEA Income Protection Plan that I want to revoke this authorization. I understand that revocation of this authorization may be a basis for denying benefits.

I also agree a photostatic copy of said authorization shall be as valid as the original.

_____/____/_________ X ____

Date Signature of Plan Participant

____

Witness' Signature

A. Workers' Compensation Agreement

X I,__________________________________, have read and understand the terms outlined in the Workers' Compensation clause of the General Accident and Sickness Provisions section of the Summary Plan Description. In the event any evidence is produced from any source to support a claim for Workers' Compensation benefits, I agree to follow said terms outlined in the Summary Plan Description. I understand that failure to supply required information may result in suspension of benefit payments until the information is provided.

B. Subrogation Reimbursement Agreement

x I,__________________________________, agree that, by accepting benefits under the MSEA Income Protection Plan for an injury or sickness arising out of or in the course of employment, I will reimburse the Contract Administrator the total amount of Income Protection Plan benefits I receive in the event my workers' compensation claim is approved or validated. My claim for workers' compensation will be deemed to have been approved if I receive any monetary amount or non-monetary compensation arising out of my work-related injury or sickness, including, but not limited to, re-instatement of leave time, payment of medical expenses (in whole or in part), or the receipt of any other benefit, whether by judgment, decree, settlement or otherwise. The recipient of such recovery may be me, my heirs, or any vendor being reimbursed for services performed or expenses incurred associated with the injury or sickness.

I also authorize any responsible third party or their insurer, workers' compensation carrier, or the representing attorney to reimburse the MSEA Income Protection Plan directly for benefits I receive as an alternative to reimbursing me, but only to the extent of any benefits received by me, my dependents or my heirs under the Income Protection Plan. In the event that I violate or breach the terms of this Subrogation Agreement, I agree to pay all costs and expenses, including reasonable attorneys' fees, for the enforcement of this Agreement by the MSEA Income Protection Plan.

X _____/_____/_____ X ____

Date Signature of Plan Participant

____

Witness' Signature

Designated Representative (Complete this section to assign someone other than yourself, i.e. spouse, child, parent, etc., the right to discuss any and all aspects of your claim with MSEA Income Protection Plan representatives.)

x Name of Representative: ____ Relationship:_______________________

Telephone #: _______________________

_____/_____/_____ X ____

Date Signature of Plan Participant

____

Witness' Signature