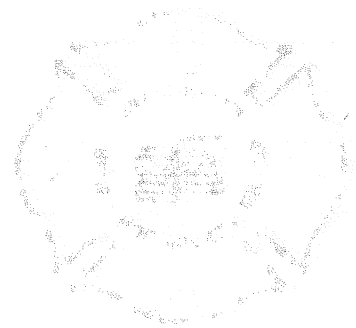
Wichita Firefighter's Relief Association
Fire Station One
731 N. Main
Wichita Ks. 67203
316-265-0545

If you were unable to work due to illness or injury and sought treatment please fill out the attached form. Complete the "Employee Section" and return it to the Association Office with the treating physician's name and address. (See example) Contact the Association office for assistance.

Physician's Name: _____
Address: _____
_____

Thank you,

Board of Directors
Wichita Firefighter's Relief Association



The STANDARD INSURANCE

Disability Claim
Employer/Employee Statement

Standard Insurance Company
PO Box 2800 Portland OR 97208-2800 800.368.2859 Tel 800.378.6053 Fax

TO BE COMPLETED BY EMPLOYER

Employee's Full Name:	Social Security No.:	Job Title: *(Please attach a copy of the job description.)*	1. Date Employed:
		Firefighter	

2. Is employee insured for Short Term Disability? ☒ Yes ☐ No
Effective date: 03/01/03
Is employee insured for Long Term Disability? ☒ Yes ☐ No
Effective date: 03/01/03
Is employee insured for Group Life Insurance through The Standard? ☒ Yes ☐ No

3. Is disability work related? ☐ Yes ☐ No ☐ Undetermined

4. Has the employee filed for: Workers' Compensation ☐ Yes ☐ No
State Disability: ☐ Yes ☐ No
Other: _____ ☐ Yes ☐ No
Weekly Amount: 66 2/3%

5. Employee's earnings: $ _____
(Check one) ☐ hourly ☐ weekly ☐ monthly ☐ annual ☐ commission ☐ other
Date of last increase: N/A Earnings prior to increase: $ N/A

6. Last active day at work:

7. Job status when disability began: ☒ Full-time (56 hours/week) ☐ Part-time (____ hours/week)

8. Date employee returned to work:

9. Last day through which sick leave benefits were paid by employer: NA FRA Policy

10. Last day through which any compensation was paid by employer: NA FRA Policy

11. Is employee subject to: Social Security taxes? ☐ Yes ☐ No
NA FRA Policy Medicare taxes? ☐ Yes ☐ No

12. What percentage of the STD premium does the **employer** pay? NA %
What percentage of the LTD premium does the **employer** pay? NA %

13. Are employee premiums paid with pre-tax dollars (IRC Section 125 cafeteria plans)? NA ☐ Yes ☐ No

Has either percentage changed within the last three years? ☐ Yes ☐ No

Employer:	Phone No.:	Policy No.:	
WFRA Wichita Fire Dept. / Wichita Firefighters	(316) 265-0545	00 132856 0001	
Mailing Address:	**City:**	**State:**	**Zip Code:**
731 N. Main	Wichita	Ks.	67203

Acknowledgement

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I acknowledge that I have read the fraud notice on the following page of this form.

Signature: Date:

TO BE COMPLETED BY EMPLOYEE

Full Name:	Social Security No.:	Phone No.: ( )	Birthdate:	Sex: ☐ M ☐ F
Address:		**City:**	**State:**	**Zip Code:**

1. Is your disability work related? ☐ Yes ☐ No

2. Have you filed a Workers' Compensation claim? ☐ Yes ☐ No

3. Do you intend to file? ☐ Yes ☐ No

4. Last active day at work:

5. Date you became unable to work at your occupation because of disability:

6. Date you returned or expect to return to work:

7. ☐ Accident. When and where did it happen?

☐ Illness. When did you first notice and what is the nature of your disability?

8. How does your disability prevent you from working?

9. Have you had a previous disability claim with The Standard? ☐ Yes ☐ No

10. Pregnancy: Expected delivery date: _____
Actual delivery date: _____
Type of delivery: ☐ Vaginal ☐ C-section

Acknowledgement

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Signature: Date:

The STANDARD INSURANCE

Authorization to Obtain Information

Standard Insurance Company
PO Box 2800 Portland OR 97208-2800 800.368.2859 Tel 800.378.6053 Fax

I AUTHORIZE THESE PERSONS having any records or knowledge of me or my health:

- Any physician, medical practitioner or health care provider.
- Any hospital, clinic, pharmacy or other medical or medically related facility or association.
- Any insurance company.
- Any employer or plan sponsor.
- Any organization or entity administering a benefit program.
- Any educational, vocational or rehabilitational organization or program.
- Any consumer reporting agency, financial institution, accountant, or tax preparer.
- Any government agency *(for example, Social Security Administration, Public Retirement System, Railroad Retirement Board, etc.).*

TO GIVE THIS INFORMATION:

- Charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing and test results. Prognosis and treatment of any physical or mental condition, including:
  - Any disorder of the immune system, including HIV, Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes.
  - Any communicable disease or disorder.
  - Any psychiatric or psychological condition, including test results.
  - Any condition, treatment, or therapy related to substance abuse, including alcohol and drugs.

  and:
- Any non-medical information requested about me, including such things as education, employment history, earnings or finances, or eligibility for other benefits *(for example, Social Security Administration, Public Retirement Systems, Railroad Retirement Board, claims status, benefit amounts and effective dates, etc.).*

TO STANDARD INSURANCE COMPANY

- I understand that The Standard will use the information to determine my eligibility or entitlement for insurance benefits.
- I understand and agree that this authorization shall remain in force throughout the duration of my claim for benefits with The Standard. I understand that I have the right to revoke this authorization at any time by sending a written statement to The Standard, and that a revocation of the authorization, or the failure to sign the authorization, may impair The Standard's ability to evaluate or process my claim. Revocation of the authorization may be a basis for denying my claim for benefits.
- I understand that in the course of conducting its business, The Standard may disclose to other parties information it has about me. The Standard may release this information about me to a reinsurer, a plan administrator, or any person performing business or legal services for The Standard in connection with my claim.
- I acknowledge that I have read the authorization and the state variations *(if applicable)* on the following page. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

Name *(please print)* _____ Social Security No. _____

Signature of Claimant/Guardian/Representative _____ Date _____

This Authorization is a two page document. Please see reverse page for additional terms and information. Both pages are part of the Authorization.

Standard Insurance Company
PO Box 2800 Portland OR 97208-2800 800.368.2859 Tel 800.378.6053 Fax

Disability Claim Attending Physician's Statement

TO BE COMPLETED BY EMPLOYEE

Full Name:	Employer:	Group Policy No.:
	Wichita Fire Dept./WFRA	00 132856 0001

The following information is needed to document the patient's inability to work. The patient is responsible for completing this form without expense to The Standard. Please complete this form and mail it to The Standard at the address listed above.

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

1. Diagnosis

A. Diagnosis:	ICDA Classification:
B. Symptoms:	C. Objective Findings: Height: Weight: B/P:

2. Pregnancy *(if applicable)*

A. Expected date of delivery:	B. Actual date of delivery:	C. Type of delivery: ☐ Vaginal ☐ C-section

D. Significant complications, if any:

3. History

A. Date you recommended the patient stop work:	B. When did symptoms appear or accident happen?
C. Has the patient ever had the same or similar condition? ☐ Yes ☐ No	If yes, when?
D. Is this condition related to the patient's employment? ☐ Yes ☐ No	E. Did you complete a workers' compensation claim form? ☐ Yes ☐ No

4. Treatment

A. Date of first visit:	B. Date(s) of subsequent visits:	C. Date of most recent visit:

D. Planned course and duration of treatment *(include surgery and medications, if any)*:

5. Level of Functional Impairment

A. Describe the patient's mental and cognitive limitations, if any.

B. In a work day given two breaks and a meal break, your patient can:

Lift *(in pounds)* ☐ 1-10 ☐ 11-20 ☐ 21-50 ☐ 51-75 ☐ 76+

Carry *(in pounds)* ☐ 1-10 ☐ 11-20 ☐ 21-50 ☐ 51-75 ☐ 76+

	Total Hours								With positional change
Sit	8	7	6	5	4	3	2	1	*(hrs)* _____
Stand	8	7	6	5	4	3	2	1	*(hrs)* _____
Walk	8	7	6	5	4	3	2	1	*(hrs)* _____
Alternately sit/stand	8	7	6	5	4	3	2	1	*(hrs)* _____

Bend/stoop: ☐ Never ☐ Occasionally ☐ Frequently

C. Is this patient competent to endorse checks and direct the use of proceeds? ☐ Yes ☐ No

6. Hospitalization *(if applicable)*

A. Date admitted:	B. Date discharged:	C. Reason:

D. Name of hospital:

7. Prognosis

A. Since onset of symptoms, the patient's condition has: ☐ Improved ☐ Not changed ☐ Retrogressed

B. When do you anticipate the patient can return to work? ☐ Date: ☐ Unable to determine, follow up in: weeks ☐ Never

8. Physician Information *(Please type or print.)*

Name of physician completing this form:			Phone No.: ( )
Specialty:	Tax ID. No.:		Fax No.: ( )
Address:	City:	State:	Zip Code:

Acknowledgement

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Signature: Date: