NAVAJO NATION EMPLOYEE BENEFIT PLAN
PRELIMINARY STATEMENT OF DISABILITY – STD

PO BOX 2069
COTTONWOOD, AZ 86326

ATTENDING PHYSICIAN'S STATEMENT OF ACCIDENT OR ILLNESS

1. Patient's Name

Date of Birth

2. Nature of injury or illness (Describe complications, if any):

3. When did accident happen or symptoms first appear? (m/d/yr)

4. When did patient first consult you for this condition? (m/d/yr)

5. Is condition due to injury or sickness arising out of patient's employment?
Yes No If yes, explain:

6. Has patient ever had same or similar condition?
Yes No If yes, state when and describe:

7. Describe any other disease or infirmity affecting present condition:

8. Date and nature of surgical or obstetrical procedure, if any. Describe fully:

9. Give dates of treatment:

OFFICE____
HOME____
HOSPITAL____

10. If patient is hospitalized give name and address:
HOSPITAL____
ADDRESS____
CITY, STATE, ZIP____
Date admitted______________ Date Discharged______________

11. How long was or will patient be continuously totally disabled. (Unable to work)?
From________________20_____Through________________20________

12. How long was or will patient be partially disabled?
From_____________20_____Through_________________20_______

13. If due to pregnancy:

LMP Date_______________EDC Date__________________

Date Delivered:______________________________
Complications, if any:

14. Is this patient competent to endorse checks and direct the proceeds with a clear understanding of the nature of his/her acts? Comments.
Yes No

(*As defined in Federal Dictionary of Occupational Titles)

Class 1 - No limitation on functional capacity; capable of heavy work* No Restrictions. (0-10%)
Class 2 - Medium manual activity* (15-30%)
Class 3 - Slight limitation of functional capacity; capable of light work* (35-55%)
Class 4 - Moderate limitation of functional capacity, capable of clerical/administrative (sedentary*) activity. (60-70%)
Class 5 - Severe limitation or functional capacity; incapable of minimum (sedentary*) activity (75-100%)

REMARKS:

Attending Physician's Name (Please Print)		Degree	
Mailing Address	City	State	Zip
Telephone ( )	Date	Signature	