NAVAJO NATION EMPLOYEE BENEFIT PLAN
PRELIMINARY STATEMENT OF DISABILITY-STD

P.O. Box 2069
Cottonwood, AZ 86326

THIS SECTION TO BE COMPLETED BY EMPLOYEE (Please Print)	Plan Number 710000	
Full Name (Last, First, M.I.)	Social Security No.	Date of Birth
Mailing Address	Employer	Home Phone ( )
City	State	Zip
Occupation	Gender ☐ Male ☐ Female	Type of Disability ☐ Accident ☐ Illness ☐ Maternity
Describe how and where accident occurred or list symptoms of illness.		
Is your injury or illness related to your work? ☐ Yes ☐ No	Date claim filed with Workers' Compensation Program	

Complete if your claim is for an accident:	Complete if your claim is for an illness:
Date accident occurred_____	Date symptoms first noticed_____
How and Where? _____	Date first treated_____
Date symptoms first noticed_____	List symptoms of illness_____
Date first treated_____	_____

If Workers' Compensation denied your claim, attach copies of denial letter, original claim filed, and Employee's Claim Petition

I have been unable to work because of the disablity since (m/d/yr):	☐ I returned to work Part Time on (m/d/yr)	☐ I returned to work Full Time on (m/d/yr)
Date first treated for illness or injury	Doctor name and address	Hospital name and address

Have you had same or similar conditions in the past? ☐ Yes ☐ No	If so, when?	Doctor name and address	Hospital name and address

Describe any other income you are receiving or are eligible to receive as a result of your disability: (Examples: Social Security, Workers' Compensation, State Disability, Pension Disability, etc.)

Describe Source	Amount of Income	Date Income Began	Date Income Ended

If your request for benefits is approved do you want us to withhold amounts from each benefit check for Federal Income Tax purpose? ☐ Yes ☐ No

If "yes", enter amount $_____ (Amount per week $20.00 minimum)

_____ Signature

AUTHORIZATION TO RELEASE INFORMATION- Must be signed and dated to validate the claim.

To: Any licensed physician, medical practitioner, hospital, clinic, or other medical related facility, insurance company, employer, or consumer reporting agency.

(1) I authorize you to release the following to HMA, Inc., their reinsurers, or any consumer reporting agency on their behalf for purposes of determining disability benefits: full information, including copies of records, concerning medical examinations, history and treatment, occupation, income, and financial status.

(2) I have a right to receive a copy of this authorization upon request. A photocopy of this authorization shall be considered as valid as the original. This authorization shall be valid for a period of one year from the date of signature.

DATE_____ SIGNATURE OF EMPLOYEE_____

THIS SECTION TO BE COMPLETED BY EMPLOYER (Please Print)

Employee's Name	Last Day Worked	Reason for Stopping Work	Date Returned Full Time	Date Returned Part Time

Date Hired	Occupation at Time of Disability	Work Schedule at Time of Disability Days/wk: Hrs/day:	Basic Annual Earnings as of Last Day Worked $

By any Employer-Employee, Labor Management, Union Welfare Plan or any State Disability, will (or has) Employee file(d) for Unemployment Compensation or for Disability provided? ☐ Yes ☐ No If yes, please specify:	Is Employee eligible for Workers' Compensation? Amount $ Carrier ☐ Yes ☐ No

Employer Address

Telephone	Title	Date	Signature

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING INFORMATION,CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.