LOS ANGELES COUNTY FIREMEN'S RELIEF ASSOCIATION

CLAIM FOR SICK OR INJURY BENEFITS

To the Board of Directors; I____ Employee No.____________
(Print Name)

Station No. __________ Shift _____, or other work location ____

Residing at ____
(Street) (City) (zip) (Telephone)

A member in good standing, I hereby certify that I was unable to perform my regular line of duties or assignment in the Los Angeles County Fire Department because of: ____
(State nature of illness or injury)

from _____________________20_____ to ______________________20_____, inclusive, a period of ______days.
(Date of illness or injury) (Date of return to work)

I understand that the disability for which I am now claiming benefits from the Association is <u>not service connected</u>. In the event this disability or its cause should hereafter be determined to be service connected. I will promptly refund all benefits I have received pursuant to this claim. The dates as shown in above claim correspond with Administrative Site records. I have read and understand the above statement.

Members Signature: ____ Date: ___________
(Please sign and date)

Send Check to: ____
(Street Address or P.O. Box)

____
(City) (Zip)

*SEE REVERSE SIDE FOR INFORMATION AND MAILING INSTRUCTIONS. *ALL CLAIMS MUST BE VERIFIED BY AN "ATTENDING PHYSICIAN'S STATEMENT".

ATTENDING PHYSICIAN'S STATEMENT

I certify that I attended to the above patient from _________________20 ____ to ______________20 ____,

inclusive. And that his/her disability was due to: ____

HE/SHE MAY RETURN TO WORK ON: ____

___________________________________ __________________
Physician's Signature Date Signed

____
(Physician's Street) (City) (Zip) (Telephone)

DO NOT WRITE IN SPACE BELOW

START DATE: __________	END DATE: __________	# OF DAYS: _________	AMT. PD: __________	CH. NO.________	DATE PD._________
START DATE: __________	END DATE: __________	# OF DAYS: _________	AMT. PD: __________	CH. NO.________	DATE PD._________
START DATE: __________	END DATE: __________	# OF DAYS: _________	AMT. PD: __________	CH. NO.________	DATE PD._________
START DATE: __________	END DATE: __________	# OF DAYS: _________	AMT. PD: __________	CH. NO.________	DATE PD._________
START DATE: __________	END DATE: __________	# OF DAYS: _________	AMT. PD: __________	CH. NO.________	DATE PD._________
START DATE: __________	END DATE: __________	# OF DAYS: _________	AMT. PD: __________	CH. NO.________	DATE PD._________
START DATE: __________	END DATE: __________	# OF DAYS: _________	AMT. PD: __________	CH. NO.________	DATE PD._________
START DATE: __________	END DATE: __________	# OF DAYS: _________	AMT. PD: __________	CH. NO.________	DATE PD._________
START DATE: __________	END DATE: __________	# OF DAYS: _________	AMT. PD: __________	CH. NO.________	DATE PD._________
START DATE: __________	END DATE: __________	# OF DAYS: _________	AMT. PD: __________	CH. NO.________	DATE PD._________

VERIFY: **MEMBER** __________
DOCTOR __________
PAYROLL _________

Revised 01/08

INFORMATION REGARDING CLAIMS

1. A member shall be entitled to a weekly benefit, upon submission of claim and proof that he/she has been unable to perform their assigned duties by reason of disability caused by illness, injury or quarantine, subject to provisions of Section 4203 of by-laws. Schedule of benefits is as follows:

   A. A minimum payment of $60.00 per week.
   B. As determined annually by the board.
   C. Temporary disability benefits shall not be paid for more than sixty weeks. (Section 4209)

2. In order to be entitled to receive benefits, a written claim must be submitted in such form and details as prescribed by the Board and the claimant must furnish proof in support thereof. (Section 4106)

3. **A CLAIM FOR BENEFITS MUST BE SUPPORTED BY THE STATEMENT OF A PHYSICIAN UNLESS WAIVED BY THE BOARD**. (Section 4109)

4. The first day of disability may be counted as the one on which a member was disabled, according to departmental payroll record, subject to Section 4203. Disability time may include any of the following: accumulated sick time, holiday time, vacation time or time exchanges. **IF DATES CLAIMED ARE CERTIFIED BY A LICENSED PHYSICIAN.** (Section 4206)

5. Claims for benefits must be on file with the Association not later than three (3) months from (a) conclusion of temporary disability, (b) retirement, (c) classification by the Board of Retirement as permanent disability, (d) death or (e) termination, as the case may be. (Section 4112)

6. **NO BENEFITS WILL BE PAID IF SUCH DISABILITY IS ACCEPTED AS SERVICE CONNECTED.** (Section 4203)

7. **Mail claims to:** Los Angeles County Firemen's Relief Association
   P. O. Box 91-1113
   Commerce, CA. 90091

AMOUNTS PAID ON THIS CLAIM

START DATE: _____ END DATE: _____ # OF DAYS: _____ AMT. PD: _____ CH. NO._____ DATE PD._____
START DATE: _____ END DATE: _____ # OF DAYS: _____ AMT. PD: _____ CH. NO._____ DATE PD._____
START DATE: _____ END DATE: _____ # OF DAYS: _____ AMT. PD: _____ CH. NO._____ DATE PD._____
START DATE: _____ END DATE: _____ # OF DAYS: _____ AMT. PD: _____ CH. NO._____ DATE PD._____
START DATE: _____ END DATE: _____ # OF DAYS: _____ AMT. PD: _____ CH. NO._____ DATE PD._____
START DATE: _____ END DATE: _____ # OF DAYS: _____ AMT. PD: _____ CH. NO._____ DATE PD._____
START DATE: _____ END DATE: _____ # OF DAYS: _____ AMT. PD: _____ CH. NO._____ DATE PD._____
START DATE: _____ END DATE: _____ # OF DAYS: _____ AMT. PD: _____ CH. NO._____ DATE PD._____
START DATE: _____ END DATE: _____ # OF DAYS: _____ AMT. PD: _____ CH. NO._____ DATE PD._____
START DATE: _____ END DATE: _____ # OF DAYS: _____ AMT. PD: _____ CH. NO._____ DATE PD._____