SAG-AFTRA HEALTH PLAN

3601 W. Olive Ave., Burbank, CA 91505 • Mailing Address: P.O. Box 7830, Burbank, CA 91510-7830
P (800) 777-4013 • F (818) 953-9880 • www.sagaftraplans.org/health

Total Disability Application Form

To avoid delays, please answer all questions completely.

This section is to be completed by the participant:

Participant last name _____ First name and middle initial _____ Health care ID (HCID) number _____

Address _____ City _____ State _____ Zip _____ Phone ( ) -

Total disability means that you are, or your adult dependent is, prevented solely because of sickness or accidental bodily injury from performing the material and substantial duties of your/his/her regular occupation. With respect to a participant or dependent who is a minor, total disability means that the disabled individual is presently suffering from sickness or accidental bodily injury the effect of which is likely to be of long or indefinite duration and which will prevent him or her from engaging in most of the normal activities of a person in good health of like age and gender.

Name of person totally disabled at the time coverage ended: _____

☐ Participant ☐ Dependent Date of birth: _____

Does the patient have other health insurance? ☐ Yes ☐ No If yes, name of coverage: _____

Please describe the cause of the patient's injury/disability. If you need more space, attach a statement to this form.

_____

Patient's occupation: _____

Nature of duties: _____

Date first treated for this injury/disability: / / Is this work-related? ☐ Yes ☐ No

Last date of work: / / Expected work return : / /

Is the patient receiving benefits as a result of this injury/disability? ☐ Yes ☐ No

If yes, please indicate the type below:

Source	Date benefit began
☐ State Disability	/ /
☐ Social Security	/ /
☐ Federal/state	/ /
☐ Workers' compensation	/ /
☐ Pension	/ /
☐ Other	/ /

Name of attending physician _____ Address _____ City _____ State _____ Zip _____ Phone _____

By signing below, you agree that all the information you provided is true and correct.

Participant signature _____ Date _____

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Attending Physician's Statement

The patient is responsible for the completion of this form at no expense to the SAG-AFTRA Health Plan.

Patient name: _____ Date of birth: ___/___/_____

Participant name: _____ HCID #: _____

1. History

a. When did symptoms first appear or accident happen? Month _____ Day _____ Year _____
b. Date patient ceased work because of disability Month _____ Day _____ Year _____
c. Is patient's condition related to employment? ☐ Yes ☐ No ☐ Unknown
d. Name and addresses of attending physicians _____

2. Diagnosis (including any complications)

a. Date of last examination Month: _____ Day: _____ Year: _____
b. Diagnosis (including any complications) _____
c. Subjective symptoms _____
d. Objective findings (including current X-rays, EKGs, laboratory data, and any clinical findings _____

3. Dates of Treatment

a. Date of first visit Month _____ Day _____ Year _____
b. Date of last visit Month _____ Day _____ Year _____
c. Frequency ☐ Weekly ☐ Monthly ☐ Other (Specify) _____

4. Nature of Treatment

_____

_____

5. Progress

a. Is patient ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed
b. Is patient ☐ Ambulatory ☐ House Confined ☐Bed Confined ☐Hospital Confined
c. Has patient been hospital confined? ☐ Yes ☐ No

If yes, give the name and address of hospital _____
Confined from _____ through _____

6. Impairment

☐ Class 1 – No limitation of functional capacity; capable of heavy work*; no restrictions (0-10% limitation)
☐ Class 2 – Medium manual activity (15-30%)
☐ Class 3 – Slight limitation of functional capacity; capable of light work* (35-55% limitation)
☐ Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity (60-70%)
☐ Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary*) activity (75-100%)

Remarks _____

**As defined in the Federal Dictionary of Occupational Titles*

7. Mental/nervous impairment (if applicable)

a. Please define "impairment" as it applies to this patient: _____

b. What stress and problems in interpersonal relations has patient had on job?

_____

☐ Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations)
☐ Class 2 – Patient is able to function in most stress and engage in interpersonal relations (no limitations)
☐ Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
☐ Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
☐ Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Remarks: _____

8. Prognosis

a. Is patient now totally disabled from engaging in or from performing the material and substantial duties of his/her regular occupation? ☐ Yes ☐ No

b. What duties of patient's job is he/she incapable of performing? _____

c. Do you expect patient to recover sufficiently to perform duties? ☐ Yes ☐ No

If yes, when will patient recover sufficiently to perform duties?

☐ Approximate date: _____ ☐ Unknown at this time

If no, please explain: _____

_____

9. Rehabilitation

a. Is patient a suitable candidate for further rehabilitation services (i.e. cardiopulmonary program, speech therapy, etc.)? ☐ Yes ☐ No

b. Can present job be modified to allow for handling with impairment? ☐ Yes ☐ No

c. When could trial employment commence? ___/___/___ ☐ Full-time ☐ Part-time ☐ Work as a performer ☐ Other work

d. Would vocational counseling and/or retraining be recommended? ☐ Yes ☐ No

10. Remarks

_____

_____

****Please include the last six (6) months of medical records with this application.****

_____ _____
Attending physician's name Degree

_____
Address

_____ _____ _____ _____
City State Zip Phone

_____ _____
Physician signature Date

Please return to:

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