



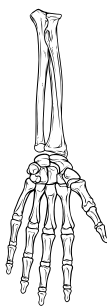

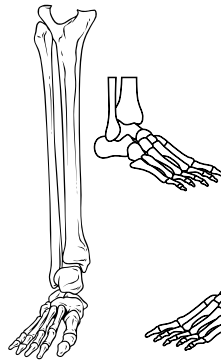

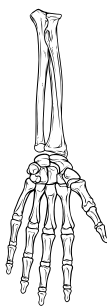

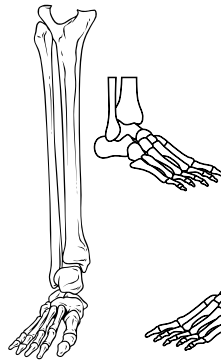

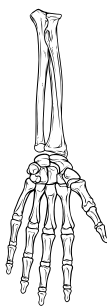

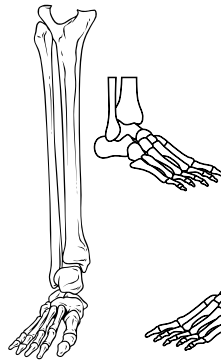

Patient information

Name (first, middle, last)	
Date of birth (mm/dd/yyyy)	Social Security number (last 4 digits)

Diagnosis and nature of injury

Date first consulted for this loss (mm/dd/yyyy)	
In your opinion, was this loss the result of an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did illness or disease contribute to the loss? <input type="checkbox"/> Yes <input type="checkbox"/> No
If the loss was the result of an accident, please explain	
At the time of the amputation or loss, was the patient receiving care or treatment for any disease or illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Was the amputation or loss of sight or hearing caused (directly or indirectly) by any physical or mental infirmity, illness, disease, self-inflicted injury, commission of a felony, drugs or poison taken voluntarily, or bacterial infection? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of accident (mm/dd/yyyy)	Time of accident
Location of accident	
Describe the accident that caused the loss	
Any contributing medical conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No	Maximum medical improvement achieved? <input type="checkbox"/> Yes <input type="checkbox"/> No

Amputation information

Which limb was amputated?	<table border="0"> <tr> <td style="text-align: center;">RIGHT</td> <td style="text-align: center;">LEFT</td> <td style="text-align: center;">RIGHT</td> <td style="text-align: center;">LEFT</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>	RIGHT	LEFT	RIGHT	LEFT				
RIGHT		LEFT	RIGHT	LEFT					
									
Where is the amputation? If applicable, please list if above or below wrist or ankle joint									
If below the joint, please identify where the amputation occurred									
Reason for the amputation									
Additional comments									

Complete and email this form to the Board of Pensions at memberservices@pensions.org.
Questions? Call the Board at 800-PRESPLAN (800-773-7752) (TTY: 711).

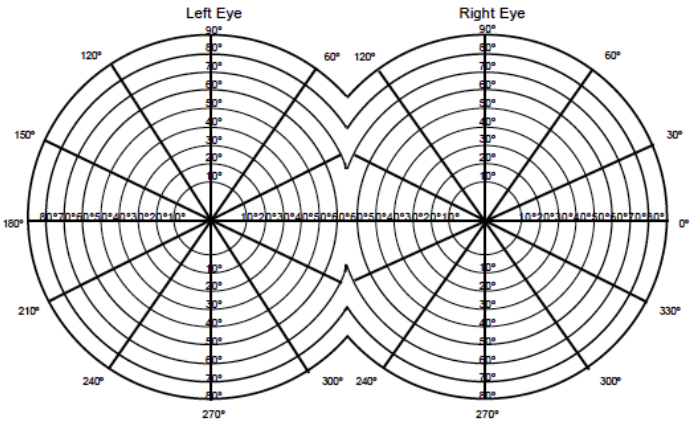


Hearing loss information

Date of loss (mm/dd/yyyy)	
Is the loss in both ears? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the loss total and irrevocable? <input type="checkbox"/> Yes <input type="checkbox"/> No

Vision loss information

Date of loss (mm/dd/yyyy)	If fields of vision are contracted, show contraction on chart below
Date of first eye exam (mm/dd/yyyy)	
Date of last eye exam (mm/dd/yyyy)	
Visual acuity with glasses OD _____ OS _____ Date _____ uncorrected OD _____ OS _____ Date _____	



If the injury necessitated the removal of one or both eyes, supply the date of surgery (mm/dd/yyyy)
Can vision be restored in whole or part by lenses, treatment, or surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No
If vision can be restored by surgery, do you recommend it? <input type="checkbox"/> Yes <input type="checkbox"/> No

Medical records

Please include copies of medical records pertaining to the amputation or loss

Fraud notice

I certify the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief.

Complete and email this form to the Board of Pensions at memberservices@pensions.org.
Questions? Call the Board at 800-PRESPLAN (800-773-7752) (TTY: 711).