U.S. Army Nonappropriated Fund
Disability Application

EBB Form 766-R

CONTROL NUMBER: GAC 3730

EMPLOYER: The form should be given to the employee with instructions to mail it when completed by the claimant and the Attending Physician to the U.S. Army Employee Benefits Branch, P.O. Box 107, Arlington, Virginia 22210-0107.

PART A (to be completed by Employee)

EMPLOYEE: (1) Please fill out and sign this portion of your Application for Group Life Insurance Disability Benefits and/or Retirement Disability Benefits and/or 401(k) Savings Plan Disability Benefits.(IMPORTANT) - Failure to fully answer all questions will cause delay in the claim processing. Should you need assistance in completing this form, contact your Employer. (2) When completed and signed by you, forward to your Attending Physician with instructions to Complete Part C and forward to the Employee Benefits Branch at the address above.

I. LAST NAME | **FIRST NAME** | **MI** | **SEX** | **SOCIAL SECURITY #**

2. DATE OF BIRTH | **MARRIED** | **NUMBER OF CHILDREN DEPENDENT UPON YOU FOR SUPPORT**

3. MAILING ADDRESS (No., Street, Apt. No., P.O. Box or Rural Route) (City) (State) (Zip Code) TELEPHONE #

4. DESCRIBE THE DUTIES OF YOUR USUAL JOB IN YOUR OWN WORDS:

JOB TITLE | **YOUR EMPLOYER**

5. DID YOUR USUAL JOB INVOLVE:

- **A. THE USE OF MACHINES, TOOLS, OR EQUIPMENT?**
- **B. TECHNICAL KNOWLEDGE OR SPECIAL SKILLS?**
- **C. ANY SUPERVISORY RESPONSIBILITIES?**
- **D. TRAVEL?**

PLEASE EXPLAIN ALL YES ANSWERS:

6. DESCRIBE THE KIND AND AMOUNT OF PHYSICAL ACTIVITY INVOLVED IN YOUR JOB DURING A TYPICAL WORK DAY (SELECT NUMBER OF HOURS IN A DAY THAT YOU PERFORM THESE ACTIONS AT WORK).

LIFTING AND CARRYING (DESCRIBE WHAT WAS LIFTED, HOW HEAVY IT WAS, HOW OFTEN IT WAS LIFTED AND HOW FAR IT WAS CARRIED).

7. HOW DOES YOUR ILLNESS OR INJURY NOW PREVENT YOU FROM PERFORMING YOUR USUAL DUTIES AS DESCRIBED IN ITEMS 4, 5 & 6?

8a. LIST ANY SKILLS WHICH YOU MAY HAVE AS A RESULT OF PRIOR EMPLOYMENT, TRAINING OR EDUCATION, OR MILITARY SERVICE:

8b. LIST LAST YEAR OF SCHOOL COMPLETED:

9. BEFORE YOU STOPPED WORKING, DID YOUR ILLNESS OR INJURY CAUSE YOU TO CHANGE:
   a. YOUR JOB OR DUTIES?
   b. YOUR HOURS OF WORK?
   c. YOUR ATTENDANCE?
   (EXPLAIN HOW YOUR CONDITION CAUSED THESE CHANGES AND SHOW THE DATES THE CHANGES WERE MADE.)

10. BRIEFLY DESCRIBE YOUR INJURY OR ILLNESS THAT PREVENTS, OR HAS PREVENTED YOU FROM WORKING:

11. IF CONDITION DUE TO INJURY, PLEASE INDICATE THE FOLLOWING:
   DATE OF INJURY | WHERE DID IT OCCUR?

12. DESCRIBE HOW ACCIDENT OCCURRED:

13. WHAT WAS YOUR LAST DAY OF WORK BECAUSE OF THIS DISABILI | ARE YOU STILL DISABLED?

14. IF YOU ARE NO LONGER DISABLED, ENTER DATE YOU WERE AGAIN TO WORK (MONTH, DAY, YEAR) | DATE OF FIRST TREATMENT FOR THIS ILLNESS OR INJURY

15. LIST THE NAME, ADDRESS AND TELEPHONE NUMBER OF THE DOCTOR WHO HAS YOUR LATEST MEDICAL RECORDS.
   IF YOU HAVE NO DOCTOR, CHECK HERE
   NAME | AREA CODE & TEL NO.
   ADDRESS

16. HOW OFTEN DO YOU SEE THIS DOCTOI | DATE OF FIRST VISIT | DATE OF LAST VISIT

17. REASONS FOR VISITS | TYPE OF TREATMENT RECEIVED:

18. HAVE YOU SEEN ANY OTHER DOCTOR SINCE YOUR ILLNESS OR INJURY BEGAN?
   IF "YES" SHOW THE FOLLOWING:
   NAME | AREA CODE & TEL NO.
   ADDRESS

19. HOW OFTEN DO YOU SEE THIS DOCTOI | DATE OF FIRST VISIT | DATE OF LAST VISIT

20. REASONS FOR VISITS | TYPE OF TREATMENT RECEIVED:

21. HAS YOUR DOCTOR TOLD YOU TO RESTRICT YOUR ACTIVITIES IN ANY WAY?
   IF "YES", GIVE NAME OF DOCTOR AND STATE WHAT HE/SHE TOLD YOU ABOUT RESTRICTING YOUR ACTIVITIES

22. CHECK ANY OF THE FOLLOWING WHICH APPLY TO YOU:

CONFINED IN A HOSPITAL OR OTHER MEDICAL INSTITUTION.
CONFINED TO A BED OR WHEEL CHAIR AT HOME.
NONE OF THE ABOVE BUT UNABLE TO GO OUTSIDE.
ABLE TO GO OUTSIDE ONLY WITH HELP OF ANOTHER PERSON OR DEVICE.
ABLE TO GO OUTSIDE WITHOUT HELP.

23. ARE YOUR HOME DUTIES, SOCIAL ACTIVITIES OR ABILITY TO CARE FOR YOUR PERSONAL NEEDS LIMITED IN ANY WAY?

IF "YES" DESCRIBE HOW AND WHY THEY ARE LIMITED.

24. DO YOU EXPECT TO RETURN TO WORK | DATE EXPECTED TO RETURN | DATE RETURNED

25. HAVE YOU BEEN SEEN BY OTHER AGENCIES FOR YOUR INJURY OR ILNESS (VA, VOCATIONAL, REHABILITATION WELFARE, ETC.)?

IF "YES" SHOW THE FOLLOWING:

NAME OF AGENCY
ADRESS OF AGENCY
YOUR CLAIM NO. | DATES OF VISITS | TYPE OF TREATMENT OR EXAMINATION RECEIVED

26. HAVE YOU EVER FILED (OR DO YOU INTEND TO FILE) CLAIMS FOR DISABILITY BENEFITS UNDER ANY:
WORKER'S COMPENSATION LAW OR PLAN?
SOCIAL SECURITY?

27. HAS THERE BEEN ANY DECISION OR ANY PAYMENT (TEMPORARY, PERMANENT, OR LUMP SUM) MADE ON THE CLAIMS FILED?

WORKER'S COMPENSATION CLAIM #s

28. ARE YOU ENTITLED TO DISABILITY BENEFITS FROM WORKER'S COMPENSATION BECAUSE OF THIS DISABILITY

SOURCES	IDENTIFY INSURANCE OR AGENCY	BENEFIT AMOUNT	HOW PAYABLE FROM	THRU
Worker's Compensation	ALEXSIS	$		

AUTHORIZATION

The above answers are true and complete according to the best of my knowledge and belief. I authorize any employer, insurance company, medical prepayment plan, service organization, physician, practioner or other person; any hospital including the Veterans Administration, or other institution to release to or obtain from the US Army Nonapprop Benefits Branch, any medical or benefit payment information that may be required to establish the validity of this claim, said company, person or organization, to disclose any personal or claim information required for medical case study or review. A photostat of this authorization shall be as valid as the original.

EMPLOYEE'S SIGNATURE_____ DATE_____

YOU MUST NOTIFY THE EMPLOYEE BENEFITS BRANCH PROMPTLY IF:

a. Your medical condition improves so that you would be able to work, even though you have not yet returned to wo
b. You go to work whether as an employee or as a self-employed person.

EBB Form 766-R (APR 2000)

ATTENDING PHYSICIAN'S STATEMENT

REPLY TO:
US ARMY NAF EMPLOYEE BENEFITS BRANCH
P.O. BOX 107
ARLINGTON, VA 22210-0107

PATIENT'S NAME _____ POLICYHOLDER NAME _____

DATE OF BIRTH_ _____ CONTROL NUMBER: GAC 3730

The purpose of this report is to assist us in making a disability determination. In filing out this report please include insufficient details of history, physical and diagnostic findings, clinical course, therapy and response to enable us to make this determination. After signing this form, return it to the address noted above.

1. HISTORY

(a) Patient's Age.....

(b) When did symptoms first appear or accident happe

(c) Date patient ceased work because of disability.....

(d) Has patient ever had same or similar condition?.....

if "Yes" state when and describe.....

2. DIAGNOSIS (including any complications)

(a) Subjective symptoms.....

(b) Objective findings.....

(including current signs, laboratory data & X-ray results)

3. DATES OF TREATMENT

(a) Date of first visit.....

(b) Date of last visit.....

(c) Frequency.....

4. NATURE OF TREATMENT (Including Surgery, if any)

5. PROGRESS

(a) Check one..... Recovered ☐ Improved ☐ Unchanges ☐ Retrogressed ☐

(b) Is patient..... Ambulatory?

Bed confined?

(c) If hospital confined..... Name of hospital

Confined from through

6. PHYSICAL IMPAIRMENT (AS IT RELATES TO EMPLOYMENT)

☐ **Class 1 - No limitation of functional capacity; capable of heavy physical activity. No restrictions. (0-10%)**

☐ **Class 2 - Slight limitation of functional capapcity; capable of light manual activity. (15-30%)**

☐ **Class 3 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity (35-55%)**

☐ **Class 4 - Marked limitation. (60-70%)**

☐ **Class 5 - Severe limitation of functional capacity; incapable of minimal (sedentary) activity. (75-100%)**

☐ **Remarks:**

5. COMPETENCY

Is the patient competent to endorse checks and direct the use of the proceeds thereof?

6. PROGNOSIS

(a) Do you expect a fundamental or marked change in the future? No / Yes-Improvement / Yes-Deterioration

	HIS JOB	OTHER WORK
(b) if improved, will patient recover sufficiently to perform duties of	No / Yes	No / Yes
	3-6 mos / 6-12 mos / over l yr	3-6 mos / 6-12 mos / over l yr

(c) If no improvement expected, please explain

7. REHABILITATION

	HIS JOB	OTHER WORK
(a) Is patient a suitable candidate for trial employment or job training?	Yes / No	Yes / No
(b) If yes, when could he commence trial employment?	full time / part-time; mos. day year	full time / part-time; mos. day year

(c) If no, please explain_

8. REMARKS

Date | Name (Attending Physician) Print | Degree | Telephone

Street Address | City or Town | State or Province | Zip Code

Signature