MERCER ISLAND DISABILITY BOARD AFFIDAVIT FROM CLAIMANT

☐ Approved for $450 or less by Board Secretary on _____ (date)

☐ Authorized for $450 or more by Board on _____ (date)

NAME OF CLAIMANT:_____

Check One: ☐ Police ☐ Fire

Check One: ☐ Active ☐ Retired If retired, please list mailing address:

_____

_____

_____

STATE OF WASHINGTON)
) ss
COUNTY OF KING)

This is to certify that I have incurred medical expenses in the amount of $_____.
(*Attached is the statement of claims processing action*).

These expenses are solely for necessary medical services as directed by my physician, Dr._____.

The injury or condition causing the expense is as follows: (if injury give details of accident causing injury.)

_____

_____

_____

_____

To the best of my knowledge I have not received compensation for these medical expenses and if compensation is forthcoming from a source other than the City of Mercer Island, I will reimburse the City immediately for those expenses. To the best of my knowledge the above information is true and correct. I hereby authorize any physician who has treated me for this condition to release my medical records to the Mercer Island Disability Board or its designee.

☐ My medical insurance is Regence Washington Health (formerly known as King County Medical)

☐ My medical insurance is LEOFF Health & Welfare Trust

☐ My medical insurance is Group Health Medical

☐ Reimbursement should be made payable to me.

☐ Reimbursement should be made payable to the provider at the name and address shown below:

_____

Signature of Claimant: _____ Date: _____