

Administrative Claim Information

1. **Information Concerning the Individual Seafarer:** *This section requests information regarding your personal data, and is self-explanatory:*

<input type="checkbox"/> Seafarer's Full Name:	
<input type="checkbox"/> Social Security Number:	
<input type="checkbox"/> Merchant Mariner's Number:	
<input type="checkbox"/> Mailing Address (street)	
<input type="checkbox"/> Mailing Address (city, state, ZIP)	
<input type="checkbox"/> Legal Residence Address (street)	
<input type="checkbox"/> Legal Residence Address (city, state, ZIP)	
<input type="checkbox"/> Date of Birth:	
<input type="checkbox"/> Place of Birth:	

2. **Information With Respect to the Basis for the Claim:** *This section requests information regarding the illness or injury you are claiming occurred in connection with your employment aboard the vessel:*

<input type="checkbox"/> Name of the Vessel:	
<input type="checkbox"/> Location on the vessel where the incident occurred:	
<input type="checkbox"/> Time of Incident (year, month, day, time)	
<input type="checkbox"/> Description of facts and circumstances of the incident. (Use reverse side of page if more space is necessary.)	
<input type="checkbox"/> Names of Others Who Can Supply Information about the Incident and Its Consequences:	

3. **Additional Information Required Regarding Employment:** *This section concerns your return to work after you were declared FFD, whether as a merchant seafarer or in a shoreside capacity.*

<input type="checkbox"/>	The date you were declared FFD (Copy of FFD slip must be attached):	
<input type="checkbox"/>	The date you re-registered with your union to return to work:	
<input type="checkbox"/>	The date you actually returned to work as a seafarer:	
<input type="checkbox"/>	Company/vessel with whom you were employed:	
<input type="checkbox"/>	If you went to work in a capacity other than as a merchant seafarer, the date, company, and position in which you went to work:	

4. **Dollar Amount of the Claim:** *This section requests information as to how this injury or illness has caused you financial loss or hardship. If you have an injury from which you have recovered, all the questions in this section may not apply to you.*

Past loss of earnings or earning capacity:

[a] How much did you earn a month? _____

[b] How many months were you unable to work? _____

[c] Lost earnings [multiply (a) by (b)]: _____

Future loss of earnings or earning capacity due to permanent disability:

[d] Do you have a permanent disability? Yes No

If "Yes" attach copy of doctor's statement indicate that you are permanently Not Fit for Sea Duty

[e] Will you be able to continue as a seafarer? Yes No

Note: If you answered "Yes" to [d] and "No" to [e], you are alleging a permanent disability and stating that you will not be able to ever return to active employment as a merchant seafarer.

Lost Earnings:

[f] How many years would you have continued to sail if you had not been injured?

[g] How much would you have earned per year? _____

[h] Multiply [f] by [g] to determine lost earnings: _____

Loss of Pension

[i] How many years do you have toward your pension? _____

[j] How many years would you have continued to sail? _____

[k] What would your pension have been if you had continued to sail? _____

Future Loss of Earnings or Earning Capacity due to Partial Disability:

[l] If you have a partial disability, will you be able to continue to sail in your prior capacity:

Yes No

[m] If "Yes", will this disability cause your earnings to be reduced, and if so, why?

Yes No

[n] If this disability will prevent you from sailing in your prior capacity, what restrictions has it caused and what shipboard jobs could you perform?

[o] How much will your earnings be reduced each year, because of (l) or (j) noted above:

[p] How many years will you continue to sail? _____

[t] Lost earnings from partial disability, multiply [k] times [l] _____

Medical Expenses Paid by Seafarer:

[r] Did you have any medical expenses paid directly by you, rather than the company or union medical plan?

Yes No

[s] If "Yes", did you submit the bills to the company or union?

Yes No

[t] If "Yes", were these bills paid by the company or union:
 Yes No

[u] If your answer to [o] is "Yes" and [p] is "No", please indicate amount of bills paid directly by you, and attach copies of billings to this form:

Pain and Suffering:

[v] How much do you feel you should be compensated for pain and suffering, and explain why you feel this payment is due. (Use reverse side of page if more space is needed):

Other Financial Loss as a Result of Injury or Illness:

[w] If you have incurred any other loss as a result of this incident, please describe and explain what compensation you feel is appropriate. (Use reverse side of page if more space is needed):

5. **Required Supporting Documentation:** *In order to review any claim, certain medical and financial information must be supplied. The required information is indicated in this section*

Medical Records: All medical and clinical records of physicians and hospitals related to the claim for injury/illness must be attached. If you do not have a copy of each record, you must identify each and every physician and hospital having records by full name and address. In addition, you must also sign the attached release (or other form of medical release if preferred) which shall provide authorization for MARAD and the Ship Manager to obtain all such records

Earnings Records: You must indicate the number of days you have worked as a seafarer during the year of the accident and during the preceding two years:

Employment time in year of accident:		<input type="checkbox"/> year(s)	<input type="checkbox"/> month(s)	<input type="checkbox"/> day(s)
Employment time in Year 1 immediately preceding accident:		<input type="checkbox"/> year(s)	<input type="checkbox"/> month(s)	<input type="checkbox"/> day(s)
Employment time in Year 2 immediately preceding accident:		<input type="checkbox"/> year(s)	<input type="checkbox"/> month(s)	<input type="checkbox"/> day(s)

Tax records for these years must be attached to support your prior earnings records.

I certify the above information to be true and correct.

Seafarer

Date

This form must be completed and returned to the Ship Manager or General Agent. In addition, a copy must also be sent to:

U.S. Department of Transportation
Maritime Administration
Division of Marine Insurance
MAR-782, Room 8117
Washington, DC 20590