

DISABILITY PLANS

	PLAN A Contract Disability	PLAN B \$11.95 per month	PLAN C \$23.95 per month
Premiums			
Coverage	Accidents (on & off duty)	Accidents (on & off duty) & Illness	Accidents (on & off duty) & Illness
Monthly Benefit	\$1,000	\$1,000	\$1,500
Elimination Period	7-day elimination period	7-day elimination period	7-day elimination period
Accidental Death Benefit	\$75,000	\$75,000	\$100,000
*Light Duty Benefit	\$175 per week with 4 week max	\$175 per week with 4 week max	\$175 per week with 4 week max

Claims must be filed within 90 days of loss. Coverage is for short term disability and requires claimant to be under a physician's care. *Light duty benefits are only available for accident claims after the claimant has met the elimination period. As of August 15, 2025, any member in Phase Down C or D who is deemed 100% disabled after entering Phase Down may be entitled to receive a one-time check for \$1,000. Eligibility is determined by the Trustees of the Houston Police Benefit Trust whose decision is final. See policy for terms and conditions.

DISABILITY CLAIM FAQ

- Complete the HSR Disability Claim Form
 - You will need to complete Part I with your general information and details of your accident/illness
 - Your supervisor will verify your last day worked in Part II
 - Your treating physician will complete Part III and provide your totally disabled dates
- Submit the claim form back to our office for processing
- Disability payments are disbursed weekly and checks are mailed to your address provided on the claim form
- Questions or concerns? Call (832) 200-3410 or email info@hpbt.us.

1. PLEASE FULLY COMPLETE THIS FORM
2. MAIL TO: Texas Police Trust
1600 State Street
Houston, TX 77007
(832) 200-3410 Phone
(832) 200-3481 Fax

HSR
Houston Police Trust
Claims administered by HSR

First Health.
Policy Name:
Texas Police Trust
Disability & Accident Illness

PART I - POLICYHOLDER'S REPORT

1. Claimant's Name (Injured Person) 2. Social Security Number 3. Gender 4. Date of Birth 5. E-Mail
COW C/P

6. Address of Injured Person and Best Contact Phone Number (Include Area Code)

7. If Applicable, Parent's Name, Address, and Best Contact Phone Number (Include Area Code)

8. Date and Time of Accident 9. Place where Accident Occurred 10. Name of Event or Activity

11. Type of Injury (Indicate Part of Body Injured - e.g. broken arm, sprained ankle, etc.) Did Injury Result in Death? ☐ YES ☐ NO

12. Describe How Accident / Illness Occurred - Give All Possible Details

13. Signature of Participant or Parent 14. Date

PART II - SUPERVISOR'S STATEMENT

1. Last Day Worked 2. Occupation at Time of Injury ☐ Yes ☐ No

3. Did Accident Occur During a Policyholder Sponsored and Supervised Activity? ☐ Yes ☐ No

4. Signature of Supervisor 5. Title 6. Date

PART III - DISABILITY APPLICATION - ATTENDING PHYSICIAN'S STATEMENT

1. Diagnosis and Concurrent Conditions (use ICD-9 codes or give names) 2. Is this condition due to injury arising out of patient's employment? ☐ Yes ☐ No

3. Date Symptoms First Appeared 4. Date Patient First Consulted You for this Condition

5. Has Patient ever had Same or Similar Condition? ☐ Yes ☐ No (If yes, when and describe)

6. Name, Address, and Best Contact Phone Number of Referring Physician

7. Is Patient Totally Disabled (unable to work)? If so, indicate the date(s) the patient is totally disabled. 8. Is Patient Partially Disabled? If so, indicate the date(s) the patient is partially disabled.

9. From Through 10. From Through

11. Is Patient Still Under Your Care for this Condition? ☐ Yes ☐ No

11. Physician's Best Contact Phone and Fax Numbers (Include area code and E-Mail Address)

12. Physician's Address (street, city, state, zip)

13. Physician's Name (Printed) 14. Physician's Signature 15. Date

I hereby authorize any insurance company, hospital, physician or other person who has attempted or attempted to determine the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A given date and time of this authorization shall be considered as effective and valid as the original.

SIGNATURE DATE

Texas Police Trust Disability & Accident Illness 8/15/2025 11:15

