UNITED

Free Choice of Personal Physician Form

Note: Pre-Designation is not available in the following states, which limit employers' and/or employees' ability to select treating physicians. As such, the following procedures will be followed:

- **Montana : employee may select treating physician. Pre-designation is not required.**
- **Nevada : employee may select treating physician from the panel. Pre-designation is not required.**
- **Oregon : employee may select treating physician. Pre-designation is not required.**
- **Texas : employee may select treating physician from the United Airlines Texas HCN. Pre-designation is not required.**
- **Washington : employee may select treating physician. Pre-designation is not required. If the state's Labor and Industry Department has established a health care provider network in the employee's geographic area, the employee must get ongoing care from a provider in that network but may see a non-network provider for the initial visit.**

In the event of an occupational injury/illness, I wish to be treated by my "personal physician"***** as permitted by the Collective Bargaining Agreement and my state Workers' Comp guidelines. I understand that in the event that I am unconscious and am in need of emergency medical treatment, United is hereby authorized to provide such treatment at an appropriate emergency medical facility or facilities.

The name and address of my physician is as follows: **(Please print legibly in all sections below)**

Physician's name: _____ Physician's Phone # : _____

Physician's address: _____ Email: _____

CA Kaiser employees only: KPOJ Region: _____ Physician's Fax #: _____

*****A "personal physician" is the employee's regular physician or surgeon (not a chiropractor or other degreed professional) who has previously directed the medical treatment of the employee and who retains the employee's medical records and medical history.

I confirm that the above named physician is indeed my personal physician and last treated me on _____ (enter date of most recent treatment with this physician).

Employee name: _____ Emp ID #: _____ Co. address code: _____

Employee preferred email address: _____

DOB: _____

Provided to:
Supervisor name: _____ **Co. address code**: _____

Supervisor signature:_____ **Date:** _____

Copies to: Employee and local medical file. Supervisor sends this form to begin validation process - via email:
WorkComp@united.com

Please <u>DO NOT</u> have your physician sign this form prior to submitting for validation.
Work Comp will send this form with a pre-designation validation letter to the physician. Validation is only confirmed by us sending this form directly to your chosen physician and the physician returning the signed form back to us.

Dear Physician:
If you agree to this pre-designation, please sign and return this form to within 15 days. You may also authorize a designated employee to sign this form on your behalf.

Physician Signature:_____ Date: _____