LOCAL 734 WELFARE FUND

6643 North Northwest Hwy • Chicago, IL 60631-1360 • (773) 594-2810 • FAX (773) 631-3824

DISABILITY FORM

EMPLOYEE'S STATEMENT

FAILURE TO COMPLETE THIS FORM IN FULL WILL DELAY THE PROCESSING OF YOUR CLAIM

MEMBER'S INFORMATION

Your Name | Date of Birth

Social Security Number ☐☐☐ ☐☐ ☐☐☐☐ | ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated | **Telephone No.** ( ) -

Your Complete Mailing Address

City | State | Zip Code

Name of Your Employer | Date Employed

SPOUSE INFORMATION

Name | Date of Birth

Social Security Number ☐☐☐ ☐☐ ☐☐☐☐ | Employment Status ☐ Active ☐ Retired ☐ Not Employed

Employer Name and Address

Name and Address of Insurance Company

Policy or Plan No. | Insurance ID Number | Type of Coverage ☐ Individual ☐ Family

PATIENT INFORMATION

Name | Date of Birth

Claim is for ☐ Illness ☐ Pregnancy ☐ Accident ☐ Other_____

Date Accident Occurred | _____ TIME ☐ A.M. ☐ P.M.

If illness describe:

Where did accident occur?

How did accident occur?

ACCIDENT OR ILLNESS DUE TO AUTO ACCIDENT? ☐ Yes ☐ No

ACCIDENT OR ILLNESS DUE TO EMPLOYMENT? ☐ Yes ☐ No

HAVE YOU OR YOUR DEPENDENT, OR WILL YOU OR YOUR DEPENDENT FILE CLAIM FOR WORKERS' COMPENSATION BENEFITS? ☐ Yes ☐ No

ARE YOU COVERED UNDER ANOTHER DISABILITY PLAN? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING SECTION

Policy or Plan No.	Insurance ID Number	Type of Coverage ☐ Individual ☐ Family	Name and Address of Insurance Company

If you were disabled for more than 7 days, what was the first date you were unable to work?

Month Day

If you have already returned to work, what date were you released for your return? Month Day

I hereby certify that the foregoing statements are true and correct to the best of my knowledge and I also authorize any hospital, physician, or other person who has attended me or examined me or my dependents to disclose when requested to do so by Local 734 Welfare Fund or its representative, any and all information with respect to any illness or injury, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original. I understand that Local 734 Welfare Fund is to pay the hospital, as determined by Local 734 Welfare Fund, in accordance with the Plan Document, directly to the provider of the service unless paid receipts are presented.

DATE | MEMBER'S SIGNATURE

EMPLOYER'S STATEMENT

Answer the following questions when member is diabled for more than 7 days.

On What Date Did Employee Last Work? _____

On What Date Did Employee Resume Work? _____

If On Vacation, Please Show Dates
From: _____
To: _____

Was The Disability Due To An On-The-Job Injury? _____

Date Completed _____

Signature & Title Of Employer's Authorized Representative _____

PHYSICIAN'S STATEMENT

1. ONSET OF ILLNESS.INJURY DATE	2. DATE YOU WERE FIRST CONSULTED FOR THIS CONDITION	3. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS ☐ YES ☐ NO	3a. IF AN EMERGENCY CHECK HERE ☐
4. DATE PATIENT ABLE TO RETURN TO WORK	5. DATES OF TOTAL DISABILITY FROM	THROUGH	Is condition due to injury or sickness arising out of patient's employment? If "yes" explain.
6. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. public health agency)		I.D. NUMBER	
7. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (if other than home or office)			

8. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE TO DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE (Use ICDA-9)

1.
2.
3.
4.
5.

9. A DATE OF SERVICE	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES, OR SUPPLIES FURNISHED FOR EACH DATE (Explain Unusual Services or) Circumstances				D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G REMARKS
		TOS	PROCEDURE CPT IV	CODE MOD					

10. YOUR PATIENT'S ACCOUNT NO.		11. TOTAL CHARGE	12. AMOUNT PAID HEALTH INS.	13. AMOUNT PAID PATIENT	14. BALANCE DUE
	15. PHYSICIAN/SUPPLIER SO. SEC. NO.		16. PHYSICIAN NAME, ADDRESS, ZIP CODE & PHONE NO.		
	17. PHYSICIAN/SUPPLIER EMPLOYER I.D. NO.				
18. SIGNATURE OF PHYSICIAN (I certify that the statements on the reverse apply to this bill and are made a part hereof.)			19. DATE SIGNED		