Local 734 Welfare Fund

6643 North Northwest Highway Chicago, IL 60631-1360 | PH: 773-594-2810 | Fax: 773-631-3824

DISABILITY FORM

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

PART 1. EMPLOYEE'S STATEMENT - To be completed by the employee

Name of Employee (Last, First, Middle)	**Member ID**	**Date of Birth** _____/_____/_____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated	**Sex** ☐ **Male** ☐ **Female**	**Telephone No.**
Employee's Complete Mailing Address (include street address, city, state, and ZIP code)		
Name of Your Employer:	**Date Employed**	

INJURY/ACCIDENT INFORMATION

Date Accident Occurred _____/_____/_____	Time of Accident ☐ A.M. ☐ P.M.	Claim is for: ☐ Illness ☐ Pregnancy ☐ Accident ☐ Other: _____
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 will you file a 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 No.	Type of Coverage	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_____ Year_____**	**Date you returned to work** Month_____ Day_____ Year_____ **Date you were released by doctor** Month_____ Day_____ Year_____

I hereby certify that the foregoing statements are true and correct and to the best of my knowledge and I also authorize any hospital, physician, or other person who has attended me or examined me to disclose when requested to do so by Local 734 Welfare Fund or its representative, any an 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 the 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.

Member's Signature: x_____ Date:_____

EMPLOYEE'S FULL NAME_____ **Identification No.**_____

Part 2. EMPLOYER'S STATEMENT - To be completed by your employer

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

On what date did Employee last work?	On what date did employee resume work?	If on vacation, provide dates.
Month_____ Day_____ Year_____	Month_____ Day_____ Year_____	From: _____/_____/_____ To: _____/_____/_____

Was the disability due to an on-the-job injury?	Did the employee file a claim for workers' compensation benefits?	
☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**	**X** **Signature & Title of Employer's Authorized Rep. Date**

Part 3. PHYSICIAN'S STATEMENT - To be completed by your physician

1. ONSET OF ILLNESS/INJURY DATE	**2.** DATE YOU WERE FIRST CONSULTED FOR THIS CONDITION	**3.** HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS?	**3a.** IF AN EMERGENCY CHECK HERE ☐
_____/_____/_____	_____/_____/_____	☐ **YES** ☐ **NO**	

4. DATE PATIENT ABLE TO RETURN TO WORK	**5.** DATES OF TOTAL DISABILITY	Is condition due to injury or sickness arising out of patient's employment? If yes, explain.
_____/_____/_____	From: ___/____/_____ To: ____/____/_____	

6. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (i.e. public health agency)	I.D. NO.
7. NAME & ADDRESS OF FACILITY WHERE SERVICES WHERE RENDERED (if other than home or office)	

8. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATED TO DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE No. 1, 2, 3, etc.)

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 PROCEDURE CPT	(Explain Unusual Services or Circumstances)	**D** DIAGNOSIS CODE	E REMARKS

10. PHYSICIAN/SUPPLIER ☐SSN or ☐EIN/TIN	**11.** PHYSICIAN NAME, ADDRESS, ZIP CODE & PHONE NO.

12. SIGNATURE OF PHYSICIAN

X_____ Date_____