

DISABILITY NOTICE: CLAIM FOR SHORT TERM DISABILITY BENEFITS AUTOMOBILE MECHANICS' LOCAL 701 UNION WELFARE FUND

500 W. Plainfield Road • Countryside, IL 60525 • (708) 482-0110 • FAX (708) 482-9140

Please check if your address has changed since your last claim

INSTRUCTIONS – PLEASE READ CAREFULLY

To enable us to give prompt attention to your claim complete this form at once, whether you have returned to work yet or not.

1. Fully complete the EMPLOYEE STATEMENT below. (Part I)
2. Have your Employer complete THE EMPLOYER STATEMENT (PART II).
3. Have your Doctor complete the ATTENDING PHYSICIAN'S STATEMENT (Reverse side).

PART I

THIS SECTION TO BE COMPLETED BY EMPLOYEE

Employee's Name _____ ID/SS# _____

Home Address _____ City _____ State _____ Zip _____

Area Code _____ Phone No. _____ Birth Date ____ / ____ / ____ Sex _____

Is this claim for an accident/injury? Yes No

If yes:

Where did it happen? _____ Date _____

How did it occur? _____

Is another party responsible for this injury? Yes No

Was the injury caused by claimant's employment? Yes No

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct, and complete. I hereby authorize any physician or any hospital to furnish and disclose all known facts concerning this disability. I will reimburse the fund for any over-payment made to me or in my behalf due to error or omission on this form.

Signature: _____ Date: _____

PART II

THIS SECTION TO BE COMPLETED BY EMPLOYER

Date employed ____ / ____ / ____

_____ name of employer

Date last worked ____ / ____ / ____ Date returned ____ / ____ / ____

_____ address

Hourly Salary

If salary, last date salary was paid ____ / ____ / ____

_____ city - state - zip code

Standard work week _____

(M-F, Sun-Th, etc.)

Light duty available? Yes No Can it be accommodated for this employee? Yes No

Signed by: (must be the person responsible for employment records)

_____ Phone No. (____) _____ Date _____

THIS SECTION TO BE COMPLETED BY THE ATTENDING PHYSICIAN

1. PATIENT'S NAME

DATE OF BIRTH

2. DIAGNOSIS AND CONCURRENT CONDITIONS *

3. IS CONDITION DUE TO INJURY OR SICKNESS ?

IS CONDITION DUE TO PATIENT'S EMPLOYMENT? YES NO

4. DATES OF SERVICES

(IF PREVIOUS FORM SUBMITTED TO THIS PLAN, YOU NEED SHOW ONLY DATES SINCE LAST REPORT)

5. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED.

6. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION?

7. PATIENT EVER HAD SAME OR SIMILAR CONDITION?

YES NO IF "YES" WHEN AND DESCRIBE:

8. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?

YES NO

9. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK).

FROM _____ THRU _____

10. PATIENT WAS HOSPITALIZED.

FROM _____ THRU _____

11. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK. PLEASE INDICATE DATE.

12. PATIENT'S NEXT SCHEDULED APPOINTMENT

REMARKS:



PHYSICIAN'S NAME (PRINT)

DEGREE

DATE / /

SIGNATURE

STREET ADDRESS

CITY OR TOWN

STATE OR PROVINCE

ZIP CODE