

STATEMENT OF DISABILITY

IMPORTANT: COMPLETE CLAIM FORM FULLY AND ACCURATELY. FILING OF FALSE CLAIMS WILL RESULT IN LEGAL ACTION TO THE FULLEST EXTENT POSSIBLE AND THE DENIAL OF FUTURE BENEFITS.

TO BE COMPLETED BY COVERED EMPLOYEE

Social Security No. _____

1. Name of Employee _____ Date of Birth _____

2. Home Address _____ No. and Street _____ City _____ State _____ Zip _____ Married Single

3. Employed by _____ Occupation _____

4. Name of Spouse _____ Employed by _____

Spouse's Employer's Complete Address _____

5. IF AN ACCIDENT WAS INVOLVED, ANSWER THE FOLLOWING:

(a) When did the accident happen? Date _____ 19____ at (hour) _____ a.m.
p.m.

(b) Was the injured person at work when the accident happened? Yes No

(c) Give a brief description of the accident _____

6. On what date were you first totally disabled by the sickness or injury? _____

7. Are you now wholly unable to physically engage in any work, occupation or business? _____

8. On what date were you last treated by a physician? _____

9. Have you returned to work? _____ If so, on what date? _____

10. Date _____ Signature of employee _____

11. 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 to Sheet Metal Workers Local No. 110 Welfare Trust Fund. A copy or photocopy of this authorization shall be valid as the original.

Date this Claim Form Signed _____ Employee's Signature _____ X **EMPLOYEE SIGN HERE**

ATTENDING PHYSICIAN'S STATEMENT

1. Patient's Name _____ Age _____

2. Nature of sickness or injury (Describe complications, if any) _____

3. (a) Date of first treatment _____ 19____

(b) Date of most recent treatment _____ 19____

(c) Frequency of treatments _____

4. The patient has been continuously disabled (unable to work) from _____ 19____ through _____ 19____

If still disabled, when should patient be able to return to work? _____ 19____

5. Remarks _____

Date _____ Signed _____ M.D. (Degree)

Address _____

Phone _____