



LOCAL 371 AMALGAMATED WELFARE TRUST FUND

290 Post Road West \* P.O. Box 470
Westport, CT 06881-0470

WEEKLY DISABILITY FORM

MEMBER'S STATEMENT OF DISABILITY

IN ORDER TO PROPERLY PROCESS ALL QUESTIONS MUST BE ANSWERED FAILURE TO DO SO WILL RESULT IN RETURN OF CLAIM FOR COMPLETION

MEMBER'S NAME: BIRTH DATE:

SOCIAL SECURITY NUMBER TELEPHONE NO.

HOME ADDRESS:

CITY: STATE: ZIP CODE:

EMPLOYER: HIRE DATE:

EMPLOYER ADDRESS:

CITY: STATE:

FULL TIME: PART TIME: HOURLY RATE:

ARE YOU EMPLOYED BY ANY OTHER EMPLOYER: YES NO
NAME AND ADDRESS OF OTHER EMPLOYER:

MY DISABILITY IS A RESULT OF (IF INJURY PLEASE STATE HOW, WHEN AND WHERE IT OCCURRED:

I BECAME DISABLED ON / / I LAST WORKED ON / /

CLAIM IS DUE TO WORK RELATED INJURY OR ILLNESS: YES NO

CLAIM IS DUE TO AUTOMOBILE ACCIDENT: YES NO

HAVE YOU FILED A WORKER'S COMPENSATION CLAIM: YES NO

ARE YOU INSTITUTING LEGAL ACTION REGARDING THIS CLAIM: YES NO

HAVE YOU EVER BEEN TREATED FOR THIS CONDITION IN THE PAST: YES NO

IF YES, PLEASE LIST NAMES AND ADDRESSES OF TREATING PHYSICIANS AND APPROXIMATE DATES:

I HEREBY CERTIFY THAT THE STATEMENTS CONTAINED HEREIN AND ATTACHED ARE TO THE BEST OF MY BELIEF, ACCURATE AND I HEREBY AUTHORIZE ALL DOCTORS, HOSPITALS OR OTHER INSTITUTIONS RENDERING CARE AND TREATMENT TO FURNISH FULL INFORMATION REGARDING THIS CLAIM (INCLUDING COMPLETE COPIES OF THEIR RECORDS).

DATE: MEMBER'S SIGNATURE:

TO BE COMPLETED BY LOCAL 371 FUND

EFFECTIVE DATE OF MEMBER'S BENEFITS: / CLASS:

HOURLY RATE: VERIFIED WITH:

DATE LAST WORKED: DATE RETURNED:

EMPLOYER:

DATE: AUTHORIZED SIGNATURE:

# DOCTOR'S STATEMENT

PATIENT'S NAME: \_\_\_\_\_ AGE \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

WAS/IS PATIENT HOSPITALIZED (IF YES PLEASE INDICATE DATES): \_\_\_\_\_

DATE OF FIRST TREATMENT FOR THIS CONDITION: \_\_\_\_\_

DATE YOU FIRST SAW PATIENT FOR THIS CONDITION: \_\_\_\_\_

TO YOUR KNOWLEDGE HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION IF YES PLEASE STATE WHEN AND DESCRIBE \_\_\_\_\_

DATE OF MOST RECENT TREATMENT FOR THIS CONDITION: \_\_\_\_\_

LAST DATE PATIENT ABLE TO WORK DUE TO THIS CONDITION: \_\_\_\_\_

APPROXIMATE DATE PATIENT ABLE TO RETURN TO WORK: \_\_\_\_\_

IS THIS DISABILITY THE RESULT OF INJURY ARISING OUT OF AND IN THE COURSE OF EMPLOYMENT OR OCCUPATIONAL DISEASE: YES \_\_\_\_\_ NO \_\_\_\_\_

IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION YES \_\_\_\_\_ NO \_\_\_\_\_

IF NO PLEASE GIVE DATE YOUR SERVICES TERMINATED \_\_\_\_\_

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## PLEASE COMPLETE FOR MATERNITY BENEFITS

IS CLAIM FOR PREGNANCY YES \_\_\_\_\_ NO \_\_\_\_\_ IF YES DATE LMP \_\_\_\_\_

DATE OF DELIVERY (ESTIMATED IF NOT YET DELIVERED) \_\_\_\_\_

IF DISABILITY IS FOR PREGNANCY AND LAST DAY WORKED IS MORE THAN TWO WEEKS PRIOR TO PATIENT'S ESTIMATED DELIVERY DATE PLEASE EXPLAIN ANY COMPLICATIONS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

DOCTOR'S NAME: \_\_\_\_\_ PHONE NO. \_\_\_\_\_

OFFICE ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

DOCTOR'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_