AMALGAMATED WELFARE TRUST FUND

LOCAL 371 *UFCW*

SHORT TERM DISABILITY FORM

Member's Statement of Disability

Member Name: _____ **Member ID #:**_____

Address: _____ **Telephone #:** _____

City/State: _____ **Zip Code:** _____

Date of Birth: _____ **Full time/Part Time:** _____

Employer Name: _____

Location: _____

Reason for Disability (Why are you unable to work?): _____

_____

What is the last date you were able to work?: _____

Is this claim due to an injury? _____ **Yes** _____ **No** **If Yes, please describe in detail how, when, and where the injury occurred:** _____

_____

Is this injury/illness related to your employment?: _____ **Yes** _____ **No**

Is the injury/illness related to an automobile accident?: _____ **Yes** _____ **No**

Are you pursuing legal action regarding this claim?: _____ **Yes** _____ **No**

Have you ever been treated for this condition in the past?: _____ **Yes** _____ **No**

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 and other institutions rendering care and treatment to furnish full information regarding this claim (Including complete copies of their records related to this condition).

Date: _____ **Member Signature:** _____

To be completed by Fund Office

Hourly Rate of Pay: _____

Company Contact: _____ Phone #: _____

LDW _____RTW_____

Company Paid Time: _____

Date: _____ Fund Representative Initials: _____

290 POST ROAD WEST, P.O. BOX 470, WESTPORT, CT 06881-0470

TEL (203) 226-4217 • 1-800-882-5556 • www.ufcw371.org

Doctor's Statement of Disability

This portion must be fully completed by treating physician only.

Forms completed prior to member's last date worked will not be accepted.

****Must submit original form. Photocopies and faxed copies will not be accepted.****

Patient Name: _____Date of Birth_____

Diagnosis: _____

Was/is patient hospitalized (If yes, please give dates:

_____

Date you first saw this patient for this condition: _____

Last date patient able to work:_____ Approximate date of return to work: _____

Dates of most recent treatment for this condition:

_____

To your knowledge has this patient ever had same or similar condition? If yes, please indicate dates and describe:_____

_____

Is this disability the result of an injury or illness arising out of or in the course of employment? _____ Yes _____ No

Is this disability the result of an injury related to an automobile accident?: _____ Yes _____ No

Is patient still under your care for this condition?: _____ Yes _____ No

BELOW MUST BE COMPLETED FOR MATERNITY BENEFITS

Date of LMP: _____

Date of Delivery (If not yet delivered please indicate due date): _____

Type of Delivery: _____

If last date worked is more than 2 weeks prior to patient's estimated date of delivery, please give a description of complications/reasons: _____

_____

TREATING PHYSICIAN INFORMATION

Physician's Name: _____

Address: _____

City/State: _____ Zip Code: _____

Phone #: _____

Date: _____ Doctor's Signature: _____