SHOP IRONWORKERS LOCAL 790 Welfare Plan

556 South Fair Oaks Avenue #30 • Pasadena CA 91105 • (866) 339-7467 • (626) 792-7335 Fax

DISABILITY CLAIM FORM

Instructions:

1. Have your Employer complete "Employer's Statement" under Part I.
2. Complete "Employee's Statement" in full under Part II.
3. Have your Physician complete "Attending Physician's Statement" on reverse side under Part III.

Please attach a copy of the check stub from your Worker's Compensation carrier. Failure to do so could delay the processing of your claim and/or delay your Health and Welfare Benefits.

PART I – EMPLOYER'S STATEMENT

1. Employee's Name _____ Social Security Number: _____
2. Date Employee Last Worked: _____ Date Returned to Work: _____
3. Please Circle the Days of the Week Employee Normally Works: Mon. Tues. Wed. Thurs. Fri. Sat. Sun.
4. Has Employee Been Terminated? Yes No 5. Regularly Scheduled Gross Weekly Wages: $_____
6. If Ordered By a Physician, is light duty available? Yes No

Name and Address of Employer: _____

Date Signed: _____ By: _____ Title: _____

Phone Number _____

PART II – EMPLOYEE'S STATEMENT

I hereby apply for benefits on account of disability.

1. Your name: _____ Date of birth: _____
2. Your address: _____
3. Social Security Number: _____ Home phone: _____
4. On what date did you Last work? _____
5. On what date were you first disabled? _____
6. Date returned to work (if not returned, give expected date of return): _____
7. Give medical cause of disability: _____
8. Did this condition result from accidental injury? Yes No

If yes, please describe the injury, date: _____ Time of day: _____

Location of injury: _____

What happened? _____

Is condition due to injury or sickness arising out of patient's employment? Yes No

If hospitalized, name of hospital: _____

Date confined: _____ Date discharged: _____

Authorization for release of medical information: I certify that the above information is true and correct. I hereby authorize all doctors, pharmacists, hospitals or other institutions rendering care and treatment to furnish the Shop Ironworkers Local 790 Welfare Plan with full information available as to the medical history, diagnosis, treatment, disability, prognosis with respect to any physical or mental condition and/or treatment of me to give any and all such information to the Shop Ironworkers Local 790 Trust Fund office or its legal representative for use in the processing of my claim. I also authorize the Shop Ironworkers Local 790 Trust Fund office to acquire, possess, utilize and disclose such information for such purpose, including the disclosure thereof of any provider of health care, any employer of the person making claim or union representing such person, or any person or entity representing any of the foregoing. This authorization shall remain valid until the claim has been fully processed, including any procedures for review or investigation of the claim after payment. I know that I have a right to receive a copy of this authorization upon request. I agree that a photocopy of this authorization shall be as valid as the original.

Date: _____ Signed: _____

Signature of Employee

PART III – TO BE COMPLETED BY THE DOCTOR (Please Print All Answers)

("Doctor means doctor of medicine (MD) or osteopathy (DO), and while practicing within the scope of his license, includes chiropractor, dentist, optometrist, podiatrist, psychologist, and upon referral by an MD or DO, a licensed clinical social worker).

Patient's name and address	Date of birth

1. Diagnosis and concurrent conditions of the patient:

2. Is condition due to injury or sickness arising out of patient's employment? ❑ Yes ❑ No

3. Dates of Service (If previous form submitted to this carrier, you need show only dates since last report)

4. Date symptoms first appeared or accident happened:

5. Date patient first consulted you for this condition.

6. Is patient still under your care for this condition? ❑ Yes ❑ No

7. Patient was continuously totally disabled (unable to perform his normal work

From _____ Thru _____

8. If still disabled, date patient should be able to return to work.

9. If answer to no. 8 is "unknown" when is patient's next scheduled appointment?

Date: _____ Physician's Name: _____ Degree: _____

Physician's Signature: _____ Phone Number: _____

Address: _____

REMARKS:

You must submit a copy of your Social Security card, along with this form.
If you are unable to supply us with a copy of your Social Security card, a W-9 Form must be completed.

ANY FEE FOR THIS INFORMATION IS NOT CHARGEABLE TO THE TRUST

Note: Any person or persons making a willful misrepresentation in completing this form shall be liable to the Trustees for any loss to the Fund resulting from such misrepresentation.