DISABILITY CLAIM FORM

PLEASE SEND ORGINAL INTO TRUST FUND OFFICE

TO BE COMPLETED BY EMPLOYER

Employee Name_____ SS# _____

NO YES

□ □ was the employee employed on the date of disability?

□ □ was the disability due to employee's occupation *(workers comp)*?

First full day unable to work:_____

Name of Employer:_____ Phone Number:_____

Employer's Signature / Title _____

TO BE COMPLETED BY EMPLOYEE

Employee Name *(Last, First, M.I.)* _____

Address_____Telephone # ( ) _____

NO YES

□ □ Have you performed any work for wages during the period you are claiming disability benefits?

□ □ Have you returned to work? ***If yes,*** date returned to work _____

□ □ Was disability due to your employment *(workers comp)*?

□ □ I am currently receiving a retirement pension.

□ □ I have applied for a retirement pension.

Disability Start Date _____ Describe Disability: _____

I hereby certify that the foregoing answers are true and correct to the best of my knowledge and hereby authorize all physicians or other persons who treated me and all hospitals or other institutions to furnish full information (including complete copies of records, tests, x-rays, etc.) regarding this claim to the administrative office. A copy or photocopy of this authorization shall be valid as the original.

Employee's Signature_____ **Date** _____

ATTENDING PHYSICIAN'S STATEMENT

DISABILITY START DATE _____

1. Diagnosis and condition(s): _____
2. Is condition due to injury or sickness arising from employment? □ **Yes** □ **No**
3. Date(s) of service: _____
4. Date symptoms first appeared or accident happened: _____
5. Date patient first consulted you for this condition: _____
6. Is patient continuously totally disabled and unable to work? □ **Yes** □ **No**
   If Yes, From (date) _____ *through (date)* _____ ← MUST HAVE DATES
7. If patient is still disabled, should be able to return to work on: Mo_____Day_____Year_____
8. Hospitalization/surgery date(s). Admitted: Mo _____ Day _____ Year _____

Physician's Name *(print or type)* _____

Physician's Degree _____ Physician's TIN# _____

Physician's Address_____ Phone Number _____

PHYSICIAN'S SIGNATURE _____**Date**_____