PLUMBERS AND PIPEFITTERS LOCAL 430
HEALTH AND WELFARE FUND

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DISABILITY/TIME LOSS BENEFITS

PART A EMPLOYEE'S STATEMENT *(MUST BE COMPLETED BYEMPLOYEE)*

1. EMPLOYEE NAME (PLEASE PRINT)	2. BIRTH DATE MO DAY YEAR	3. SOCIAL SECURITY NO. / /
4. ADDRESS ☐ CHECK HERE IF NEW ADDRESS CITY STATE ZIP		5. PHONE NO. ( )
6. EMPLOYER (Or Company you work for)		
6 a. ADDRESS CITY STATE ZIP		7. PHONE NO. ( )
8. IS THIS CLAIM FOR AN ACCIDENT? ☐ YES ☐ NO	**8 a. IF YES – WHERE DID IT HAPPEN?**	
9. WHEN? MO DAY YEAR	**10. DID THIS ACCIDENT/INJURY OCCUR ON THE JOB?** ☐ YES ☐ NO	
11. NAME AND ADDRESS OF PERSON RESPONSIBLE FOR ACCIDENT OR INJURY:		
12. NAME, ADDRESS AND CLAIM NUMBER OF RESPONSIBLE PERSON'S INSURANCE COMPANY:		
13. HAVE YOU APPLIED FOR OR ARE YOU CURRENTLY DRAWING UNEMPLOYMENT BENEFITS?" ☐ YES ☐ NO		

14. LAST DAY WORKED / /	2. DATE RETURNED TO WORK-**IF APPLICABLE:** Complete this section if the employee has returned to work. If beginning of disability, please check "Unknown/NA": Date:_____/_____/_____ ☐ Unknown/NA	3. DID INJURY (**IF APPLICABLE)** OCCUR ON THE JOB? ☐ YES ☐ NO

15. EMPLOYEE STATEMENT AND AUTHORIZATION TO RELEASE INFORMATION:

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. I will reimburse the fund for any overpayment made to me or in my behalf due to error on this form. I understand that it is a federal crime, punishable by fine or imprisonment, or both, to knowingly make false statements on this benefit claim form.

_____ _____

Employee Signature Date

******* CLAIM CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE *******

PART B PHYSICIAN'S STATEMENT OF DISABILITY *(MUST BE COMPLETED BY PHYSICIAN)*

1. PATIENT'S NAME: (PLEASE PRINT)		2. SOCIAL SECURITY NUMBER / /
3. ICD.10 CODE WITH DESCRIPTION		4. IF DIAGNOSIS IS PREGNANCY, PLEASE LIST DUE DATE
5. DATE PATIENT DISABLED FROM WORK	6. DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK (REQUIRED)	7. DATE PATIENT RELEASED TO RETURN TO WORK:
8. DATES PATIENT WAS FIRST SEEN FOR THIS DISABILITY	IS THIS A SCHEDULED SURGERY? ☐ YES ☐ NO IF YES, PLEASE PROVIDE THE DATE:	
9. FEDERAL TAX ID NUMBER	10. PHONE NUMBER	11. FAX NUMBER
12. PHYSICIAN NAME (PRINT)	13. PHYSICIAN CREDENTIALS (PRINT)	14. DATE
15. PHYSICIAN'S ADDRESS		16. PHYSICIAN'S SIGNATURE