Applicant Please Read & Complete All Non-Shaded Areas of Form

| Employer # | Employer<br>**PLUMBERS & STEAMFITTERS LOCAL UNION #248** | Date of Hire |
|---|---|---|

| Social Security Number | Name-Last | First | MI | Date of Birth | Gender<br>□ Male<br>□ Female |
|---|---|---|---|---|---|

| Status<br>□ Single<br>□ Married<br>□ Divorced | Home Address-Street | City | State | Zip |
|---|---|---|---|---|
| | County | Home Telephone | Current Local Union No. | |

| Do you have more than One Employer:<br>□ Yes □ No | Other Employer Name and Address |
|---|---|

What Is Your Job title? Describe Daily Duties

## CLAIM INFORMATION

| Type of Disability<br>□ Accident □ Illness □ Pregnancy | Describe How And Where Accident Occurred Or List Symptoms Of Illness And Diagnosis |
|---|---|

| Date You Last Worked | Have You Returned To Work?<br>□ Yes □ No | If "Yes", On What Date:<br>________ Part-Time ________ Full –Time |
|---|---|---|

If You Have Not Returned To Work, On What Date Do You Expect To Return To Work:
________ Part-Time ________ Full –Time

| Date First Seen By Physician | Physician(s) Name and Address |
|---|---|

| If Hospitalized, Indicate Dates of Confinement<br>From Thru | Was Any Surgery Performed?<br>□ Yes □ No | Type of Surgery |
|---|---|---|
| Date of Surgery | Surgeon's Name | |

Do You Have Any Other Insurance? □ Yes □ No
If "Yes" please complete the following

| Name of Policy Holder | Policy # | Name & Address of Insurance Co. |
|---|---|---|

Are you Receiving Any Benefit As a Result of Your Disability? Yes □ No □

| | | |
|---|---|---|
| □ Yes □ No Primary Social Security | Amount | Date Benefits Began, or Will Begin |
| □ Yes □ No Family Social Security | Amount | Date Benefits Began, or Will Begin |
| □ Yes □ No Workers Compensation | Amount | Date Benefits Began, or Will Begin |
| □ Yes □ No Pension Plan | Amount | Date Benefits Began, or Will Begin |
| □ Yes □ No Federal, State, Municipal, Railroad Retirement or Other Government Agencies | Amount | Date Benefits Began, or Will Begin |

I certify that the above information is complete and accurate to the best of my knowledge. I understand that any intentional false statements or willful misrepresentations may result in legal prosecution. I authorize any provider of service in possession of any medical information concerning me to release such information to you upon request. I know that a photographic copy of this authorization shall be as valid as the original. I agree this authorization shall be valid for the duration of the claim.

If I receive a disability benefit greater that that which I should have been paid, I understand this insurance company has the right to recover such overpayments from me, including the rights to reduce or adjust future benefits, if any.

| DATE: | EMPLOYEE SIGNATURE: |
|---|---|

THE PATIENT MUST PAY ANY COSTS FOR COMPLETION OF THIS FORM

**TO BE COMPLETED BY ATTENDING PHYSICIAN**

| Patients Name - Last | First | MI | Date of Birth | Sex ◻ M ◻ F |
|---|---|---|---|---|
| Describe Nature of Disability, Your Diagnosis Including Complications | | | | |

| Patient's Symptoms Result From (Check All That Apply) ◻ Employment ◻ Accident ◻ Illness ◻ Auto Accident ◻ Pregnancy | If Pregnancy, Give Expected/ Actual Delivery Date | Type of Delivery |
|---|---|---|

| Has Patient Had Same or Similar Condition? ◻ Yes ◻ No | Is Condition Due To Injury or Sickness Arising Out of Patient's Employment? ◻ Yes ◻ No |
|---|---|
| Date Symptoms First Appeared or Accident | Date First Treatment Received For This Disability |
| First Date Unable To Work | Expected /Actual Return To Work Date : ____________ Part-Time ____________ Full –Time |

Please Provide Dates And Place of All Medical Treatment.

| Date of Service | Place of Service |
|---|---|
| | |
| | |

What Type of Treatment Is Being Rendered?

What Is The Frequency of Treatment?

What Medication (If Any) Is Being Prescribed?

| Was Patient Hospitalized? ◻ Yes ◻ No | Date Admitted | Discharge |
|---|---|---|

Name of Hospital

If Surgery Was Performed, Give Nature of Surgery And Date

What Type of Physical Work Related Activities Is Patient Unable To Perform Due To His/Her Condition?

| Is Patient Totally Disabled (Unable To Do Any Work?) ◻ Yes ◻ No | If Yes, From | Thru | If still disabled, date patient should be able to return to work full time |
|---|---|---|---|
| Is Patient Still Under Your Care For This Condition? ◻ Yes ◻ No | | | If No, Give Date of Last Treatment |

Remarks

| Date | Signature (Attending Physician) | Degree | Phone Number | |
|---|---|---|---|---|
| Street Address | | City | State | Zip Code |

**TO BE COMPLETED BY EMPLOYER OR AUTHORIZED REPRESENTATIVE**

Employer Name

| Employee Name - Last | First | MI | Wage | ◻ Hourly ◻ Salary |
|---|---|---|---|---|

Employee Current Status
◻ Active ◻ Terminated ◻ Leave Of Absence ◻ Cobra ◻ Temporary Layoff ◻ Disabled ◻ Other ◻ Retired

| Employee Effective Date | Employee Termination Date | Date Last Worked | Date of Returned If Back to work |
|---|---|---|---|

| Date | Signature And Title of Authorized Representative |
|---|---|