Plumbers and Steamfitters Local Union No. 248
Health and Welfare Trust Fund

333 West Vine Street • Suite 500 • Lexington, Kentucky 40507
Toll-Free 888-999-7741 • Fax 859-226-1191

Employer #	Employer PLUMBERS & STEAMFITTERS LOCAL UNION # 248				Date of Hire
Social Security Number	Name-Last	First	MI	Date of Birth	Gender ☐ Male ☐ Female
Status ☐ Single ☐ Married ☐ Divorced	Home Address-Street	City		State	Zip
	County	Home Phone			Current Local No.
Do you have more than one Employer? ☐ Yes ☐ No	Other Employer Name and Address:				
What is your job title?	Describe Daily Duties:				

CLAIM INFORMATION

Type of Disability: ☐ 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? If yes, on what date? ☐ Yes ☐ No	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: From: Thru:	Was Any Surgery Performed? ☐ Yes ☐ No	Type of Surgery:

Do You Have Any Other Insurance? If yes please complete the following: ☐ Yes ☐ No	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 than 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:

Name-Last	First	MI	Date of Birth	Sex ☐ Male ☐ Female

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:	Date Discharged:
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:

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 Return, If Back to Work

Date:	**Signature and Title of Authorized Representative:**