

DISABILITY CLAIM STATEMENT



SECTION A EMPLOYEE'S STATEMENT

Employee's name _____ Social Security # _____

Address _____ Telephone # _____

City _____ State _____ Zip _____

Signature _____ Local Union # _____

Did you lose time from work because of this disability? Yes No

If, yes, give date last worked before becoming totally disabled _____, 20 _____ AM PM

and date of return ____/____/____ or expected return to work ____/____/____

Claim is for an Accident a Sickness

Briefly describe (for example: heart, pregnancy, fall, etc.) _____

Did sickness or injury arise out of or in the course of any employment? Yes No Date: _____

COMPLETE IF CLAIM IS FOR AN ACCIDENT

Date / Time _____ Where _____ How _____

SECTION B ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

Patient's full name _____ Age _____

We need your current evaluation of the patient's convalescence. May we have your opinion on the following questions?

(1) The patient has been continuously disabled (unable to work) from _____ 20 ____ through _____ 20 ____

If still disabled, when should patient be able to return to work? _____

(2) Nature of sickness or injury (Describe complications, if any) _____

(3) Dates of Services (If previous from submitted, you need show only dates since last report only) _____ 20 ____)

(4) Is patient still under your care for this condition? Yes No If no, give discharge date _____ 20 ____

(5) Please provide any additional information serving to explain extent and / or duration of this disability _____

Dated _____, 20 ____

Physician's Name (Printed)

Signature

Degrees

Telephone #

Street Address

City/Town

State

Zip Code

SECTION C EMPLOYER'S STATEMENT

Name of Employee _____ Date last worked _____

Is employee still employed by you: Yes No

Has employee resumed work? Yes No If yes, give date _____ 20 ____

Are benefits payable under Workmen's Compensation for this disability? Yes No

Has employee been: Laid off Terminated Retired

Dated _____ 20 ____ Company Name _____

Address _____

City, State, Zip _____

Signature of Authorized Representative _____ Title _____