

CLAIM FOR WEEKLY DISABILITY BENEFITS PIPE TRADES INDUSTRY HEALTH AND WELFARE PLAN

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P.O. BOX 3040 — TERRE HAUTE, INDIANA 47803
Telephone: — a/c 812-877-2581

THIS PART TO BE COMPLETED BY EMPLOYEE:

YOUR LOCAL UNION NO. _____

Employee's Name _____ Soc. Sec. No. _____

Address _____ Phone No. _____

DATE DISABILITY BEGAN _____

Was disability job related? _____

If disability is due to an accident, describe briefly what happened: _____

Have you worked since sickness commenced? _____. If so, list dates worked: _____

Are you working now? _____. I certify that I was unable to work due to sickness or injury during the week beginning _____ and ending _____.

In the case of a claim for the Weekly Disability Benefit, the weeks for which you are claiming benefits must have passed. Multiple weeks may be included on a single claim form only when properly certified by the attending physician for a period prior to the date signed by the doctor. Benefits are payable on the basis of seven (7) day periods. In the case of sickness, you **WILL NOT** be paid for the first seven (7) days; however, a form properly certifying that you were under the care of a doctor during that week must be filed. Each form must be signed by a doctor who verifies that you were unable to work during the period for which you are claiming benefits. **ALL CLAIMS MUST BE FILED WITHIN 90 DAYS OF THE FIRST DAY OF DISABILITY.**

SIGNED _____
(EMPLOYEE'S SIGNATURE)

DOCTOR'S REPORT

Not to be completed until Employee completes above section.

Physician's Name _____ Phone No. _____

Address _____

Date unable to work due to disability _____ Date Released _____

Diagnosis of disability: _____

I certify the above named individual was unable to perform work of his trade during the week designated above.

Date _____ SIGNED BY DOCTOR _____

DO NOT WRITE IN THIS SPACE - FOR OFFICE USE ONLY

Amount _____

Payment No. _____

Remarks:

