

Eighth District Fringe Benefit Funds
Temporary Total Disability

Return completed form to:

Eighth District Electrical Fringe Benefit Fund
P.O. Box 30751
Salt Lake City, UT 84130-0751

Trust Fund Phone #: (314) 656-1085
Toll Free #: (844) 989-2321
Fax #: (925) 462-0108

Part I – To be completed by PARTICIPANT (Each question must be fully answered)

1. Name _____ 2. Birth date: _____ SSN: _____
Street _____ 3. Last date of work before disability _____
City and State _____ Zip code _____ Member's Phone# _____
4. My disability is _____ Injury? _____
Illness? _____
5. It happened: Date _____ at Work? _____
Time _____ At Home? _____
6. How did it happen? _____
7. Job Description? _____

To Physicians, Hospitals and Other Institutions: I hereby authorize you by this form (or by photographic copy hereof) to give Eighth District Electrical Fringe Benefit Fund any information you have regarding my medical history and physical condition.

I certify the above answers are true and complete to the best of my knowledge and belief.

Dated _____ Mr. _____ Mrs. _____ Miss _____
SIGNATURE – Please Do Not Print

Part II – ATTENDING PHYSICIAN'S STATEMENT

1. Nature of sickness or injury/ICD9 (Describe complications if any) _____

2. Was this sickness or injury caused by patient's employment? Yes _____ No _____
Illness? _____ Injury? _____
Was it aggravated by Patient's employment? If "Yes" explain _____
3. Nature of surgical procedure, if any/CPT (Describe fully) _____

4. Date performed: _____
5. Give dates of treatments:
FIRST CONSULTATION OTHER CONSULTATIONS DURING THIS PERIOD OF DISABILITY
Office _____
Hospital _____
6. The patient has been continuously disabled (unable to work): From _____
Through (if unsure give tentative date) _____
If still disabled, when should patient be able to return to work? _____
7. Remarks _____
Date _____ Physician's Name (Print) _____ Degree _____
Physician's Signature _____
Address _____
Physician's Phone Number _____