

## **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

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**Part 1 – To be completed by PARTICIPANT (Each question must be fully answered)**

1. Name \_\_\_\_\_
2. Birth date: \_\_\_\_\_ SSN: \_\_\_\_\_
- Street \_\_\_\_\_
- City and State \_\_\_\_\_
3. Last date of work before disability \_\_\_\_\_  
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

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**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 Office _____	OTHER CONSULTATIONS DURING THIS PERIOD OF DISABILITY _____
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 \_\_\_\_\_

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