ARIZONA PIPE TRADES

ADMINISTRATIVE OFFICES

HEALTH & WELFARE, PENSION AND DEFINED CONTRIBUTION
3109 N. 24th Street, Suite 105 ♦ Phoenix, AZ 85016
Office: 602.956.1950 ♦ Toll-Free: 877.429.7473 ♦ Fax: 602.956.3016
www.azpipe.org

Weekly Disability Form

Return completed form to:
Arizona Pipe Trades Trust Fund c/o BeneSys
P.O. Box 4660
Troy, MI 48099-4660

Trust Fund Phone #: (602) 956-1950
Toll Free #: (877) 429-7473
Fax #: (248) 556-2596

Part 1 – 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 Arizona Pipe Trades Trust 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 totally 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 _____