BAC of MICHIGAN HEALTH WELFARE FUND
P.O. Box 99490
Troy MI 48099-9490
Phone 248-828-6000
Fax 248-828-6001

WEEKLY DISABILITY FORM

Craft, Local_____ID #_____
Employee Name_____
Employee Address_____

_____
Telephone Number _____

PLEASE COMPLETE ALL AREAS

Date of Birth_____
Employed by_____
Occupation_____ Last Day Worked_____
Date of Accident or Sickness Began_____
Were you injured in the course of employment?_____
Claim Made: Workers' Compensation_____
State Unemployment_____
If collecting Unemployment, not eligible for disability benefits.
Nature of sickness or injury, include diagnosis. If injured , how and where did accident occur

_____
_____
Physician's Name:_____
Physician's Address_____

WORKERS' COMPENSATION ASSIGNMENT

Employee understands that benefits are not payable by this Fund for any accidental bodily injury, sickness or occupational disease which arises out of or occurs in the course of any occupation or employment for wage or profit.

In the event any Workers' Compensation payment is made to the Employee for part or all of the disability covered by this claim form, at any time, whether by way of decision, redemption, voluntary payment or otherwise, the Employee hereby assigns to the Detroit and Vicinity Trowel Trades Health and Welfare Fund that portion of any such payment equal to the benefits paid by the said Fund to or on behalf of the Employee.

The Employee Agrees to notify the Fund, at least thirty (30) days prior to the date and location of the trial or redemption of any such Workers' Compensation Claim. "Payments cannot excced 26 weeks"

Employee's Signature_____ Date _____

EMPLOYER'S CERTIFICATE

This statement is necessary for consideration of any weekly benefits to which employee may be entitled.

Employee left employment because of _____

Was a claim filed for Workers' Compensation?_____

Was a claim filed for State Unemployment?_____

Last day worked_____Date returned to work_____

Signed_____Date_____

** Your completed Claim form must be received by the Fund Office as soon as possible after accident or Illness, but no later than 180 days after the accident or onset of Illness.

Payments cannot exceed 26 weeks

ATTENDING PHYSICIAN'S STATEMENT

1) Patient's Name _____

2) Patient Date of Birth: _____

3) Nature of sickness or injury (Describe complications, if any) **Diagnosis Code:**_____

_____

_____

4) Did this sickness or injury arise out of patient's employment: Yes or No (circle one)
If yes, explain _____

_____

5)Nature of surgical or obstetrical procedure, if any **(Describe Fully)**

_____

_____

_____

6) Date Performed:_____

Where performed: Hospital Inpatient:_____ Hospital Outpatient:_____
Physician Office_____ Other:_____

What other services, if any, did you provide the patient? (Itemize, giving dates)

_____

_____

7) Patient has been continuously disabled (Unable to work)

From:_____ Through: _____

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

Signed:_____ Date:_____
Attending Physician

Address: _____

_____

Tax ID #:_____ Telephone #: _____

Payments cannot exceed 26 weeks