BC00

Bricklayers and Allied Craft Workers
Welfare Fund of Western Pennsylvania
Weekly Disability Application

Return completed documents to:

Bricklayers and Allied Craft Workers Welfare Fund of Western Pennsylvania
P. O. Box 160
Troy, MI 48099-0160

Phone: (877) 270-1199
Email to: stdisability@benesys.com
Fax to: (248) 556-2596

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

1. Name: _____ Birth Date: _____ SSN/Alt ID: _____

   Street: _____ City and State: _____ Zip: _____

   Phone: _____ Email: _____ Employer: _____

2. Last date of work before disability: _____ 3. Date disability started: _____

4. Did your disability happen at work? Yes _____ No_____ 5. Is your disability the result of: Accident _____ Illness _____

6. Please explain your Disability. If the result of an accident, advise, how, when and where it occurred: _____

_____

7. Have you, or do you intend to file this claim under Workmen's Compensation? Yes _____ No _____

8. Have you received Unemployment Compensation Benefits since your last day of work? Yes _____ No _____

9. To Physicians, Hospitals and Other Institutions: I hereby authorize you by this form (or by copy) to provide the Bricklayers and Allied Craft Workers Welfare Fund of Western Pennsylvania with 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.

Participant Signature (do not print): _____ **Date**: _____

Part II – ATTENDING PHYSICIAN'S STATEMENT

1. Nature of disability/ICD-10 (Describe complications if any): _____
2. Was this sickness or injury caused by the patient's employment? Yes _____ No _____
3. Nature of surgical procedure, if any/CPT: _____
4. Date surgery performed: _____
5. Dates of Treatment, indicate first and any following Consultations: _____
6. The patient has been continuously disabled (unable to work): **From:** _____ **Through** _____
   (if unsure provide tentative date)
7. If still disabled, when should patient be able to return to work? _____

Physician's Signature: _____ **Date:** _____

Physician's Name (please print): _____ License: _____

Address: _____ Physician's Phone Number: (____) _____

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Part III – Optional – DIRECT DEPOSIT

1. Employee's Name: _____ Employee's SSN: _____
2. Bank Name: _____ City / State /Zip _____
3. Routing / Transit No.: _____ Account No.: _____
4. Is this a: CHECKING account ☐ SAVINGS account: ☐

Signed: _____ Date: _____