Ironworkers Intermountain Health and Welfare Trust Fund
Weekly Disability Form

Return completed form to:

Email: stdisability@benesys.com

Ironworkers Intermountain Health and Welfare Trust Fund
PO Box 30580
Salt Lake City, UT 84130

Trust Fund Phone #: (801) 904-4897
Toll Free #: (888) 867-9510
Fax #: (801) 386-7396

PLEASE NOTE: *If your disability is related to a non-occupational accident you must also apply for IMPACT, the Ironworkers Intermountain H&W Trust Fund will pay for any weeks NOT covered by IMPACT.*

Part I – To be complete 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 Ironworkers Intermountain 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 CONSULATION	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: _____
