MAN-U SERVICE CONTRACT TRUST FUND

7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046
800-638-8824

Dear Sir or Madam:

In order that we may consider your claim for Accident and Sickness Benefits, please have your doctor complete the form below and return it to this office.

This form cannot be processed unless both sides are completed.

CERTIFICATION OF ATTENDING PHYSICIAN

To Be Completed by Member's Attending Physician

I certify I attended _____
(NAME OF PATIENT) (SSN)

_____
(ADDRESS)

Date of first treatment _____ Date of latest treatment _____ Total # of treatments _____

Is disability due to accident?_____ Nature of injury _____
(Yes/No)

INJURY

Brief history_____

ILLNESS

Diagnosis_____

Is this illness or accident due to member's occupation?_____
(Yes/No)

I certify that he/she was under my care, **totally** disabled and prevented from performing all the duties

of his/her occupation from _____ to _____.
(MM/DD/YY) (MM/DD/YY)

I estimate further duration of total disability for _____ days. (Answer if patient is still disabled)

Additional Remarks: _____

_____

_____

If confined to hospital - Date admitted _____ Date discharged _____

_____ _____ _____
(Physician's Signature) (Date) (Physician's Phone)

_____ _____
(Federal I.D. Number) (Physician's Address)

-OVER-

CLAIMANT: PLEASE COMPLETE AND SIGN

Name _____ Social Security Number _____

Employer _____

Date last worked _____ Date returned to work _____

Cause of disability _____

If the disability was due to an accident, please state when, where and how it occurred _____

_____

Was injury or illness caused by your employment? _____ Yes _____ No

Are you receiving Worker's Compensation Benefits? _____ Yes _____ No

Are you receiving Unemployment Compensation? _____ Yes _____ No

Remarks _____

_____

_____

I understand that payment for any period of disability in connection with this claim is not authorized for periods during which I have received or hereafter may receive payments through Worker's Compensation and/or Unemployment Compensation. Any claim for and/or receipt of payment for any period during which such other payments are received will cause any payment from the Fund to be unauthorized, and the Fund will require the reimbursement for these payments and will immediately offset any benefits due on behalf of myself or my dependents against amounts owed to the Fund until the Fund is repaid in full.

Payments are considered received for the entire period of disability if a settlement in any amount is agreed to.

I understand that if reimbursement is not made, the Fund may also pursue its claims against me in a Court of Law.

_____ _____

(Date) (Signature)

_____

(Signature)