NORTHWESTERN OHIO PLUMBERS AND PIPEFITTERS BENEFIT PLANS

7570 Caple Blvd., Suite B / Northwood, Ohio 43619 / Telephone (419) 662-1388 / Fax (419) 662-1733

APPLICATION FOR TEMPORARY DISABILITY BENEFITS

Instructions: *Every item must be completed in full by yourself, your doctor and employer (if applicable) in order for this claim to be considered. Please return this completed form to the above address within 90 days of your disability.*

MEMBER STATEMENT (Please Print)

Member's Full Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ Phone Number: _____

Name of Last Employer: _____Date Last Employed: _____

Have you or do you intend to present a request for Worker's Compensation* arising out of this disability? _____

Are you currently or do you plan on receiving State Unemployment Benefits*? _____

When was your last State Unemployment check? _____

*You are unable to receive Disability Benefits while receiving Unemployment or Workers Compensation Benefits.

INJURY

Date of Injury: _____ Where did the accident happen? _____

How did the accident happen? _____

Is disability a result of employment? _____

ILLNESS

Date illness began: _____ When was the physician first consulted? _____

I certify that the above information is true and correct. I hereby authorize all doctors, hospitals or other institutions rendering care and treatment to furnish NWOPP Health and Welfare Fund will full information regarding treatment rendered.

Date: _____ Member's Signature: _____

EMPLOYER'S STATEMENT (Please Print)

Date last worked: _____ Has employment terminated? Yes ____ No ____ If yes, when? _____

Did disability occur due to occupational causes? Yes _____ No _____

Signature of Employer Representative: _____ Date: _____

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ATTENDING PHYSICIANS STATEMENT (Please Print)

Member's Name: _____ Date of Birth: _____

Today's Date: _____ Name of referring Physician: _____

Date first consulted for this condition: _____ Has patient ever had same or similar symptoms? Yes ___ No ____

Patient was/is continuously disabled (unable to work) From: _____ through _____

Patient's estimated return to work date: _____

Hospitalization Dates: Admitted _____ Discharged _____

Diagnosis or Nature of Illness or Injury: _____, _____, _____, _____

Prognosis: _____

_____

_____

Physician's comments: _____

_____

_____

Signature of Physician: _____ Federal Tax ID Number: _____

Physician's Address: _____

Physician's Phone Number: _____ Fax Number: _____