OHIO BRICKLAYERS HEALTH and WELFARE FUND
PO Box 99550
Troy, MI 48099
(833) 289-4921 □ (248) 641-4921

Accident and Sickness Claim Form

Note: You must answer all questions completely or your application for benefits will be denied

TO BE COMPLETED BY THE EMPLOYEE:

EMPLOYEE'S NAME (PLEASE PRINT)

ADDRESS

CITY STATE ZIP

DATE OF BIRTH SOCIAL SECURITY #

PHONE NUMBER

COMPLETE ONLY IF CLAIM CAUSED BY INJURY	DATE OF INJURY, HOUR (AM/PM), WHERE DID ACCIDENT OCCUR?	
	HOW DID ACCIDENT HAPPEN?	
COMPLETE ONLY IF CLAIM CAUSED BY ILLNESS	HAS THIS CONDITION BEEN TREATED BEFORE?	☐ YES ☐ NO
	WHAT DATE WAS THE PHYSICIAN FIRST CONSULTED?	
COMPLETE FOR ANY DISABILITY CLAIM	FIRST DATE YOU WERE UNABLE TO WORK	
	DATE YOU RETURNED TO WORK	
	IF YOU HAVE NOT RETURNED, DATE YOU EXPECT TO RETURN	
	IS DISABILITY THE RESULT OF EMPLOYMENT?	☐ YES ☐ NO

HAVE YOU FILED, OR DO YOU INTEND TO FILE, A CLAIM FOR BENEFITS UNDER WORKMEN'S COMPENSATION ACT? ☐ YES ☐ NO

HAVE YOU RECEIVED UNEMPLOYEMENT COMPENSATION BENEFITS SINCE YOUR LAST DAY OF WORK? YES NO

IF SO, FOR WHAT PERIOD OF TIME? FROM: _____ TO: _____

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 THE OHIO BRICKLAYERS HEALTH AND WELFARE FUND WITH FULL INFORMATION REGARDING TREATMENT RENDERED, INCLUDING COPIES OF THEIR RECORDS. I ALSO AUTHORIZE ANY UNION TRUST FUND, EMPLOYER OR INSURANCE CARRIER TO FURNISH THE OHIO BRICKLAYERS HEALTH AND WELFARE FUND WITH INFORMATION REGARDING BENEFITS TO WHICH I OR ANY OF MY DEPENDENTS MAY BE ENTITLED TO.

DATE EMPLOYEE'S SIGNATURE

PART A	TO BE COMPLETED BY EMPLOYER	
OCCUPATION	DATE LAST WORKED	DATE RETURNED TO WORK
HAS EMPLOYMENT TERMINATED? ☐ YES ☐ NO	WHEN	REASON
DOES THE EMPLOYEE HAVE OTHER INSURANCE COVERAGE FOR THIS CLAIM? ☐ YES ☐ NO IF YES, EXPLAIN		
DID DISABILITY OCCUR DUE TO OCCUPATIONAL CAUSE? ☐ YES ☐ NO		

SIGNATURE OF EMPLOYER TITLE DATE

PART B	ATTENDING PHYSICIAN'S STATEMENT	
1. DIAGNOSIS AND CURRENT CONDITIONS (IF DIAGNOSIS CODE OTHER THAN ICDA USED, GIVE NAME)		
2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF A PATIENT'S EMPLOYMENT?	☐ YES ☐ NO	
3. IS CONDITION DUE TO PREGNANCY?	☐ YES NO☐	IF YES, DATE PREGNANCY BEGAN:
4. REPORT OF SERVICES (OR ATTACH OFFICE NOTES) (IF SUBSEQUENT FORM, ONLY SHOW NEW DATES OF SERVICE)		
DATES OF SERVICE	PLACE OF SERVICE	TYPE OF SERVICE

5. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED	6. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION
7. HAS PATIENT EVER HAD THE SAME OR A SIMILAR CONDITION BEFORE? IF YES, PLEASE DESCRIBE	8. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?
☐ YES ☐ NO	☐ YES ☐ NO
9. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK)	
FROM THRU	
10. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO FULL DUTIES	
11. IF CONTINUING DISABILITY, DATE OF NEXT EVALUATION	

DATE PHYSICIAN'S SIGNATURE

PHYSICIAN'S NAME (PLEASE PRINT) DEGREE

ADDRESS CITY STATE ZIP

PHONE NUMBER FAX NUMBER