Disability Claim Form Painters District Council # 2 Welfare Plan	Mail Claim Forms To: Painters District Council No. 2 P.O Box 1186 Maryland Heights, MO 63043-1186

PART 1: MUST BE COMPLETED BY PARTICIPANT

Participant Name:	Social Security #:	Date of Birth:	Home Phone #.
Home Address:	City:	State:	Zip:
Name of Employer:	Employer Phone #:	Is Disability Work Related? ☐ YES ☐ NO	Job Title:

IS THE CLAIM A RESULT OF AN ACCIDENTAL INJURY: ☐ YES ☐ NO

IF YES:

How,when and where did the accident occur? _____

_____

Did the injury occur in the course of employment? ☐ YES ☐ NO

Certification and Authorization to Release Information

I hereby certify that the above information is true and correct to the best of my knowledge. I understand that a falsification or withholding of material facts may result in loss of benefits. For the purpose of determining eligibility for benefits and claim processing, I hereby authorize BeneSys, Inc. to receive from and/or provide to medical practitioners, medically-related facilities, insurance companies or like orgazinations or my employer, information as to any physical or mental condition of of myself. I know that I have the right to receive a copy of this authorization. I agree a photographic copy is as valid as the origional.

X_____ X _____

Participants Signature Date

PART 2: TO BE COMPLETED BY PHYSICIAN

Patients's Name:	Date of First visit for Current Condition:
Diagnosis and Concurrent Condition (s):	Is Sickness or Accident Related to Participants Employment? ☐ Yes ☐ No
If hospitalized, name and address of facility:	If disability is due to pregnance, expected date of delivery:

Was Surgery Performed? ☐ Yes ☐ No If yes, give date and type of surgery performed:

Considering the claimant's occupation, could the claimant resume duties of his usual and customary work while continuing treatment? ☐ Yes ☐ No If No, please explain why:

Is patient still under your care? ☐ Yes ☐ No

Date last seen: _____ Next Appointment: _____

Patient was continuously diabled (unable to work) from: to _____	Patient released to work:

If off longer that the normal length of disability for this condition, please list complication (s):

If still disabled, date patient is expected to be released to return to work: _____

Attending Physician:	Tax ID Number:
Address:	Phone:

Signature of Attending Physician: X _____ Date X _____