Plumbers and Pipefitters Local 219

Health and Welfare Trust Fund

3660 Stutz Dr. Suite 101
Canfield, Ohio 44406

Email: ShortTermDisability@benesys.com
Telephone: (330) 779-8859
Fax: (248) 556-2596

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:

Name _____

Address _____

City, State, Zip Code _____

Date of Birth _____ SSN (last 4 digits) xxx - xx - _____

Phone No. _____

Name of Last Employer _____

Date Last Employed _____

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

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

HAVE YOU RECEIVED UNEMPLOYMENT 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 Plumbers and Pipefitters Local 219 Health and Welfare Trust Fund with information regarding treatment rendered, including copies of their records. I also authorize any union trust fund, employer, or insurance carrier to furnish the Plumbers and Pipefitters Local 219 Health and Welfare Trust Fund with information regarding benefits to which I or any of my dependents may be entitled to.

Date _____ Employee's Signature _____

ATTENDING PHYSICIAN'S STATEMENT ON NEXT PAGE

PART A	TO BE COMPLETED BY PATIENT (EMPLOYEE)			
			xxx – xx –	
PATIENT'S NAME		DATE OF BIRTH	SSN (LAST 4 DIGITS)	
PATIENT'S ADDRESS	CITY	STATE	ZIP	PHONE

CLAIMANT'S ASSIGNMENT (READ BEFORE SIGNING)

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.

_____

SIGNATURE OF CLAIMANT DATE

PART B	ATTENDING PHYSICIAN'S STATEMENT	
1. DIAGNOSIS AND CURRENT CONDITIONS (IF DIAGNOSIS CODE OTHER THAN ICA USED, GIVE NAME)		
2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF 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 SIMILAR CONDITION BEFORE? IF YES, PLEASE DESCRIBE YES ☐ NO ☐	8. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? 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: _____	

_____

PHYSICIAN'S SIGNATURE DATE

_____

PHYSICIAN'S NAME (PLEASE PRINT) DEGREE

_____

ADDRESS CITY STATE ZIP

_____

PHONE NUMBER FAX NUMBER

PLEASE FAX COMPLETED FORM TO (248) 556-2596, EMAIL TO ShortTermDisability@benesys.com, **OR MAIL TO 3660 Stutz Dr. Suite 101, Canfield, OH. 44406**