SHEET METAL WORKERS LOCAL 292
FRINGE BENEFIT FUNDS
P.O. Box 189
Troy, MI 48099-0189
(248) 641-4992 (888) 646-6565

APPLICATION FOR WORK COMPENSATION CLAIM

Name: ______________________________

Soc. Sec. No.: ______________ Date of Birth: ______________

Address: ______________________________

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Telephone Number: ______________

Name of Employer at the time disability commenced: ______________

Work Compensation Benefit Information:

Work Compensation Carrier Name: ______________

Phone: ______________

Address: ______________________________

Number and Street **City** **State** **Zip Code**

Claim or Policy Number: ______________ **Agent:** ______________

Claims Office: ______________________________

The Following information is required by the Fund Office for processing your claim:

1. **The above application must be completed.**
2. **A medical form completed and filed by the Employee and the Attending Physician.**
3. **Copies of the Work Compensation Checks you receive from your Work Compensation carrier.**

Signature of Applicant: ______________________________ Date: ______________