Brick Masons Local # 4 Disability Application

Return completed form to:

Brick Masons Local # 4
PO Box 430
West Covina, CA 91793

Trust Fund Phone #: (626) 646-1080
Toll Free #: (877) 516-0586
Fax #: (626) 931-1368

Part 1 – To be completed by INSURED EMPLOYEE (**Each question must be fully answered**)

1. Name _____ 2. Birth date: _____SSN: _____
   Street _____ 3. Last date of work before disability _____
   City and State_____ Zip code_____ Member's Phone#_____
4. My disability is_____ Injury? _____
   Illness? _____
5. It happened: Date_____ at Work? _____
   Time_____ At Home? _____
6. How did it happen? _____
   _____

To Physicians, Hospitals and Other Institutions: I hereby authorize you by this form (or by photographic copy hereof) to give Brick Masons Local # 4 Health and Welfare Trust any information you have regarding my medical history and physical condition.

I certify the above answers are true and complete to the best of my knowledge and belief.

Dated_____ Mr._____ Mrs._____ Miss_____ _____
SIGNATURE – Please Do Not Print

Part II – ATTENDING PHYSICIAN'S STATEMENT

1. Nature of sickness or injury/ICD9 (Describe complications if any) _____
   _____
2. Was this sickness or injury caused by patient's employment? Yes_____ No_____
   Illness? _____ Injury? _____
   Was it aggravated by Patient's employment? If "Yes" explain_____
3. Nature of surgical procedure, if any/CPT (Describe fully) _____
   _____
4. Date performed: _____
5. Give dates of treatments:

	FIRST CONSULATION	OTHER CONSULTATIONS DURING THIS PERIOD OF DISABILITY
Office	_____	_____
Hospital	_____	_____

6. The patient has been continuously disabled (unable to work): From_____
   Through (if unsure give tentative date) _____
   If still disabled, when should patient be able to return to work? _____
7. Remarks_____
   Date _____ Physician's Name (Print) _____Degree_____
   Physician's Signature_____
   Address_____
   Physician's Phone Number_____