PLUMBERS & STEAMFITTERS
LOCAL 166
HEALTH & WELFARE FUND
P.O. BOX 99485
TROY, MI. 48099-9485
(248) 641-4966 or Toll Free (855) 641-4966

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

NAME OF LAST EMPLOYER DATE LAST EMPLOYED

COMPLETE ONLY IF CLAIM CAUSED BY INJURY	DATE OF INJURY, HOUR (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 IF CLAIM INCLUDES DISABILITY BENEFIT FOR EMPLOYEES	FIRST DATE YOU WERE UNABLE TO WORK:
	DATE YOU RETURNED TO WORK:
	IS DISABILITY A RESULT OF EMPLOYMENT? ☐ YES ☐ NO

I CERTIFY THAT THE ABOVE INFORAMTION IS TRUE AND CORRECT. I HERBY AUTHORIZE ALL DOCTORS, HOSPITALS OR OTHER INSTITUTIONS RENDERING CARE AND TREATMENT TO FURNISH THE PLUMBERS & STEAMFITTERS LOCAL 166 WELFARE PLAN 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 UA LOCAL 166 WELFARE PLAN WITH INFORMATION REGUARDING BENEFITS TO WHICH I OR ANY OF MY DEPENDENTS MAY BE ENTITLED TO.

DATE EMPLOYEE'S SIGNATURE

PLEASE BE SURE TO ATTACH ITEMIZED BILLS

TO BE COMPLETED BY EMPLOYER FOR EMPLOYEE WEEKLY DISABILITY BENEFITS ONLY.

OCCUPATION:	LAST DATE WORKED:	DATE RETURNED TO WORK:	DID DISABILITY OCCUR DUE TO OCCUPATIONAL CAUSES? ☐ YES ☐ NO
HAS EMPLOYMENT TERMINATED? ☐ YES ☐ NO	WHEN?	REASON?	
DOES THE EMPLOYEE HAVE OTHER INSURANCE COVERAGE FOR THIS CLAIM? ☐ YES ☐ NO	IF YES, EXPLAIN:		

EMPLOYER: SIGNED BY:
DATE: TITLE:

ATTENDING PHYSICIAN'S STATEMENT ON REVERSE SIDE

PART A TO BE COMPLETED BY PATIENT (EMPLOYEE)

PATIENT'S NAME	DATE OF BIRTH	SOCIAL SECURITY NO

PATIENT'S ADDRESS	CITY	STATE	ZIP	PHONE

CLAIMANT'S ASSIGNMENT (READ BEFORE SIGNING):

I HEREBY AUTHORIZE THE PLUMBERS & STEAMFITTERS LOCAL 166 WELFARE PLAN TO PAY DIRECTLY TO THE ABOVE NAMED PHYSICIAN THE MEDICAL OR SURGICAL EXPENSE BENEFITS TO WHICH I AM ENTITLED UNDER THE TERMS OF THE PLAN TO THE EXTENT OF HIS INTEREST AS ESTABLISHED HEREWITH.

SIGNATURE OF CLAIMANT _____ DATE _____

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

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 PATIENT'S EMPLOYMENT? ☐ YES ☐ NO

PREGNANCY? ☐ YES ☐ NO IF YES, APPROXIMATE DATE PREGNANCY COMMENCED: _____

3. REPORT OF SERVICES (OR ATTACH ITEMIZED BILL) (IF PREVIOUS FORM SUBMITTED, ONLY SHOW DATES AND SERVICES SINCE LAST REPORT)

DATE OF SERVICES	PLACE OF SERVICES†	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE-IF USED (IF CODE OTHER THAN CPT** USED, GIVE NAME)	CHARGES

IO - DOCTOR'S OFFICE IH - INPATIENT HOSPITAL NH - NURSING HOME

H - PATIENT'S HOME OH - OUTPATIENT HOSPITAL OL - OTHER LOCATION

*ICDA INTERNATIONAL CLASSIFICATION OF DISEASES

** CPT- CURRENT PROCEDURAL TERMINOLOGY (CURRENT EDITION)

TOTAL CHARGES: $ _____

AMOUNT PAID: $ _____

BALANCE DUE: $ _____

4. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED	5. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION
6. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? ☐ YES ☐ NO IF YES, WHEN AND DESCRIBE:	7. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO
8. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK): FROM THRU	9. PATIENT WAS PARTIALLY DISABLED FROM THRU
10. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK	11. PATIENT WAS HOUSE CONFINED FROM THRU
12. DOES PATIENT HAVE OTHER HEALTH COVERAGE? ☐ YES ☐ NO IF YES, PLEASE IDENTIFY	MUST BE FURNISHED UNDER AUTHORITY OF LAW, INDIVIDUAL PRACTITIONERS -SS NO. ALL OTHERS -I.D. NO.
13. I DO NOT ACCEPT ASSIGNMENT ☐	

DATE	PHYSICIAN'S NAME (PRINT)	SIGNATURE	DEGREE

ADDRESS	CITY	ST	ZIP	TELEPHONE

MEMORANDUM REGARDING DISPOSITION OF THIS FORM ON REVERSE SIDE

APPROVED BY COUNCIL ON MEDICAL SERVICE. AMA 10-62