



# Plumbers and Pipefitters Local 94

## Health and Welfare Trust Fund

3660 Stutz Dr, Suite 101  
Canfield, Ohio 44406

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### 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 <input type="checkbox"/> NO <input type="checkbox"/>  WHEN WAS THE PHYSICIAN FIRST CONSULTED? DATE: _____
COMPLETE FOR <u>ANY</u> 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 <input type="checkbox"/> NO <input type="checkbox"/>

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 94 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 94 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 <input type="checkbox"/> NO <input type="checkbox"/>			
3. IS CONDITION DUE TO PREGNANCY? YES <input type="checkbox"/> NO <input type="checkbox"/>		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 <input type="checkbox"/> NO <input type="checkbox"/>	8. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? YES <input type="checkbox"/> NO <input type="checkbox"/>
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](mailto:ShortTermDisability@benesys.com),  
OR MAIL TO 3660 Stutz Drive, Suite 101, Canfield, OH 44406**