

# PLUMBERS & PIPEFITTERS LOCAL NO. 520 HEALTH AND WELFARE FUND

P.O. Box 6480, Harrisburg, PA 17112

717-671-8551 – Fax (717)-671-8602

## PARTICIPANT'S STATEMENT

## DISABILITY CLAIM FORM

Participant Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_ Home Phone # \_\_\_\_\_

Address \_\_\_\_\_

Nature of Sickness or Injury \_\_\_\_\_

If Accident, when and where did accident happen? \_\_\_\_\_

Describe Accident? \_\_\_\_\_

If hospitalized, name of Hospital \_\_\_\_\_

Admission Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Physician Name and Address \_\_\_\_\_

Did your disability arise out of your employment? \_\_\_\_\_ Yes \_\_\_\_\_ No (Check One)

Will this claim for benefits be made under any other policy or with any other Company \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes – Company name \_\_\_\_\_

I hereby authorize any insurance company, prepayment organization, employer, hospital, or physician, to release to D. H. Evans Associates, Inc. or their duly authorized representative, all information with respect to me which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I understand that in signing this authorization I waive the right for such information to be privileged. A photostatic copy of this authorization shall be considered as effective and valid as the original. I certify that the information given by me in support of this claim is true and correct.

Date \_\_\_\_\_ Participant's Signature \_\_\_\_\_

## PHYSICIAN'S STATEMENT

Cause and Nature of Disability \_\_\_\_\_ ICD-9 Code \_\_\_\_\_

Has patient been hospitalized for present disability? \_\_\_\_\_ Yes \_\_\_\_\_ No If Yes, give dates and names of:

Hospital \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Date of first treatment \_\_\_\_\_ Date of most recent treatment \_\_\_\_\_

Next visit schedule for \_\_\_\_\_ Frequency of treatments \_\_\_\_\_

The patient has been continuously disabled (unable to work) \_\_\_\_\_

From \_\_\_\_\_ To \_\_\_\_\_

If still disabled, when should patient be able to return to work? \_\_\_\_\_

If any change in previous diagnosis prolonging disability, please explain \_\_\_\_\_

Remarks: \_\_\_\_\_

Physician's Name (Please print) \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_