

**STATEMENT OF CLAIM**  
**for**  
**WEEKLY DISABILITY BENEFITS**

**IMPORTANT: COMPLETE CLAIM FORM FULLY AND ACCURATELY. FILING OF FALSE CLAIMS WILL RESULT IN LEGAL ACTION TO THE FULLEST EXTENT POSSIBLE AND THE DENIAL OF FUTURE BENEFITS.**

**PART 1 - EMPLOYEE COMPLETES IN ALL CASES.**

Social Security No. \_\_\_\_\_

Local Union No. \_\_\_\_\_

1. Name of Employee \_\_\_\_\_ Date of Birth \_\_\_\_\_

2. Home Address \_\_\_\_\_ Married  Single   
No. and Street City State Zip

3. IF ACCIDENT WAS INVOLVED, ANSWER THE FOLLOWING:

a) When did the accident happen? Date: \_\_\_\_\_ 20\_\_ .. at (hour) \_\_\_\_\_ am/pm

b) Was the injured person at work when the accident happened?  Yes  No

c) Was claim filed with Workman's Compensation?  Yes  No

d) Give a brief description of the accident \_\_\_\_\_

e) Was there a third party involved?  Yes  No

f) Was a claim filed with the third party's liability insurance for this claim?  Yes  No

3. On what date were you first totally disabled by the sickness or injury? \_\_\_\_\_

4. On what date were you first treated by a physician? \_\_\_\_\_

5. On what date did you last work? \_\_\_\_\_

6. Are you still totally disabled by this sickness or injury? \_\_\_\_\_

7. Are you now wholly unable to physically engage in any work, occupation or business? \_\_\_\_\_

8. On what date were you last treated by a physician? \_\_\_\_\_

9. Have you returned to work? \_\_\_\_\_ (a) If so, on what date? \_\_\_\_\_

(b) If not, when do you expect to return to work? \_\_\_\_\_

10. Have you applied for Social Security Disability benefits? \_\_\_\_\_ Yes \_\_\_\_\_ No

a) Provide the effective date of the benefit. \_\_\_\_\_

b) Provide the amount of the monthly benefit. \_\_\_\_\_

11. Have you applied for any Disability Pension Benefit? \_\_\_\_\_ Yes \_\_\_\_\_ No

a) Provide the effective date of the benefit. \_\_\_\_\_

b) Provide the amount of the monthly benefit. \_\_\_\_\_

12. I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and believe to be true, correct and complete. I hereby authorize any physician, or any hospital, to furnish and disclose all known facts concerning this disability to 4<sup>th</sup> District IBEW Health Fund. A copy or photocopy of this authorization shall be valid as the original.

Date this Claim  
Form Signed \_\_\_\_\_

Employee's  
Signature \_\_\_\_\_

Employee Sign Here  
\_\_\_\_\_

**THE ATTENDING PHYSICIAN MUST COMPLETE THE NEXT PAGE SIDE OF THIS FORM.**

**PART 2- ATTENDING PHYSICIAN'S STATEMENT**

1. Patient's name \_\_\_\_\_ Age \_\_\_\_\_ Accident Case? \_\_\_\_\_  
 (Yes or No)
2. Nature of sickness or injury (Describe complications, if any) \_\_\_\_\_  
 \_\_\_\_\_
3. Did this sickness or injury arise out of patient's employment? Yes \_\_\_\_\_ No \_\_\_\_\_  
 If "Yes," explain \_\_\_\_\_

Date of Illness (First Symptom) or Injury (Accident) or Pregnancy (LMP)	Mo.	Day	Yr.	Date Patient First Consulted You for this Condition	Mo.	Day	Yr.	Has Patient ever had Same Similar Symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No

A DATE OF SERVICE	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN		D DIAGNOSIS CODE	E CHARGES	F
		Procedure Code (Identify)	(Explain unusual services or circumstances)			

4. The patient has been continuously disabled (unable to work) from \_\_\_\_\_, 20\_\_\_\_ through \_\_\_\_\_, 20\_\_\_\_  
 If still disabled, when should patient be able to return to work? \_\_\_\_\_, 20\_\_\_\_
5. To your knowledge, does patient have other health insurance or health plan coverage? If "Yes," identify.  
 Yes  \_\_\_\_\_ No

Date \_\_\_\_\_, 20\_\_\_\_ Signed \_\_\_\_\_ M.D.

Physician's T.I.N. \_\_\_\_\_ Address \_\_\_\_\_  
 (Must be furnished under authority of law.)

**RETURN THIS FORM TO:  
 4TH DISTRICT IBEW HEALTH FUND  
 3150 U. S. Route 60  
 Ona, WV 25545  
 304-525-0331**