Pipe Fitters' Local 597
**WELFARE & RETIREMENT FUNDS**

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# WEEKLY ACCIDENT AND SICKNESS – INITIAL FORM

Member's Statement of Claim for Group Accident and Health Benefits

**I hereby apply for benefits on account of total disability which is in no way connected with or due to my employment and I am not currently receiving unemployment.**

**TO BE COMPLETED BY MEMBER**

Member's Name _____
First Middle Initial Last

Social Security Number Local 597 Union Card Number

Address _____
Street City State Zip Code

Phone Number E-Mail Address

Is the Claim the Result of a Work Related Illness or Injury? Yes ☐ No ☐

Last Date of Work / / Name of Company

Date Total Disability Commenced / / Date Total Disability Ceased / /

| Is Claim Due to an Accident? Yes ☐ No ☐ | If Yes, Where did Accident Occur? | Date of Accident / / |
|---|---|---|

Describe Accident

*Authorization to Release Information: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment.* ***All questions must be answered. Return completed claim form to the Fund Office.***

_____ / /
Member's Signature Date

**It is the member's responsibility to notify the Fund Office upon physician's release to return to work**. It may become necessary for the Fund Office to send a form to you from time to time confirming your disability. This form must be completed by you and your physician and returned to the Fund Office in order that your benefits may continue. If you fail to notify the Fund Office of your return date to employment, you will be responsible to reimburse the Fund in full for any monies paid to you after your return date.

_____ / /
Member's Signature Date

**TO BE COMPLETED BY ATTENDING PHYSICIAN**

Diagnosis and Concurrent Conditions

Is Condition Due to Injury or Sickness Arising out of Patient's Employment? Yes ☐ No ☐

Dates of Services / / , / / , / / , / /

Date Symptoms First Appeared or Accident Happened / /

Date Patient First Consulted You for this Condition / /

Date of Disability and Approximate Date when Member Will be Able to Return to Work: From / / Thru / /

Date Member Returned to Work / /

Physician's Name Physician's Degree

Physician's Signature Phone Number

Address _____
Street City State Zip Code

Date / /