

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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Last Date of Work		Name of Company		
Date Total Disability Commenced		Date Total Disability Ceased		
Is Claim Due to an Accident? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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				