**STRUCTURAL IRON WORKERS**

**LOCAL NO. 1 WELFARE FUND**

**STATEMENT OF EMPLOYER**

# Disability Claim

Administered by:

**Group Administrators, Ltd**

 **953 American Ln, Suite 100, Schaumburg, IL 60173**

|  |  |  |
| --- | --- | --- |
| Employee’s Name  |  | I.D. No. Unit or Div. No.  |
| Date By  **/ /**   | Title  | Telephone # **( ) ―**  |
|  (Signature) **INSTRUCTIONS TO EMPLOYEE**  |   |  Area Code  |
| (1)  (2)   | This form is to be filed as soon as it appears that you will qualify for disability benefits. Complete the **Statement Of Employee** and the **Authorization For Release Of Information** below.  | (3)  (4)   |  | Have your physician complete the Attending Physician’s Statement on the reverse side. Return Form to Group Administrators, Ltd. *(see address above)*   |



**STATEMENT OF EMPLOYEE**

|  |
| --- |
| In order to process a claim for benefits, I authorize any physician, hospital or other medical provider to release to Group Administrators, Ltd., or its representative, any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered as effective and valid as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed one year from the date signed. I understand I have the right to receive a copy of this authorization. Date Signature of Employee  |
| Address of Employee   |
|  Street City State Zip Code  |
| Is this a new address?  |  |  **Yes**  |  |  **No**  |
|  |  |

## DISABILITY CLAIM

**ATTENDING PHYSICIAN’S STATEMENT**

**1. HISTORY**

(

a)

Mo.

When did symptoms first appear or accident happen?.....................................................

Day

Year

(

b)

Mo.

Date patient ceased work because of disability?...............................................................

Day

Year

(

c)

Has patient ever had same or similar condition?...............................................................

 **Yes**

 **No**

*If “Yes” state when and describe*

d)

(

Is condition due to injury or sickness arising out of patient’s employment?......................

 **Yes**

 **No**

 **Unknown**

(

e)

Names and addresses of other treating physicians...........................................................

**2**

**.**

**DIAGNOSIS**

(

a)

Diagnosis (including any complications)

1. Subjective symptoms

1. Objective findings (including current X-rays, EKG’s, Laboratory Data and any clinical findings

**3**

**.**

**DATES OF TREATMENT**

Mo.

Date of first visit..................................................................................................................

(

a)

Day

Year

Mo.

Date of last visit..................................................................................................................

b)

(

Day

Year

Frequency..........................................................................................................................

c)

(

 **Weekly**

 **Monthly**

 **Other**

(

Specify

)

**NATURE OF TREATMENT**

**4**

**.**

**(**

**Including Surgery and medications prescribed, if any)**

**.**

**PROGRESS**

**5**

(

Has patient...................................................................................................

a)

 **Recovered**

 **Improved**

**Unchanged**

 **Retrogressed**

Is patient.......................................................................................................

b)

(

 **Ambulatory**

 **House confined**

 **Bed confined**

 **Hospital confined**

(

c)

Has patient been hospital confined?

 **Yes**

**No**

 If yes, give Name and Address of Hospital

Confined from

**/**

**/**

through

**/**

**/**

**CARDIAC (If Applicable)**

**.**

**6**

(

a)

Functional capacity......................................................................................

 **Class 1**

No limitation

)

(

 **Class 2**

(

)

Slight limitation

(

American Heart Association

)......................................................................

 **Class 3**

Marked limitation

)

(

 **Class 4**

(

)

Complete limitation

Blood Pressure (last visit)..............................................................................

b)

(

**/**

SYSTOLIC

DIASTOLIC

**PROGNOSIS**

**.**

**7**

**ANY OTHER WORK**

**PATIENT’S JOB**

Is patient now totally disabled?...................................................................................................

a)

(

 **Yes**

 **No**

 **Yes**

 **No**

incapable

What duties of patient’s job is he/she

b)

(

 of performing?

(

c)

Do you expect a fundamental or marked change in the future?................................................

 **Yes**

 **No**

 **Yes**

 **No**

If yes, when will/or did patient recover sufficiently to perform duties?.......................................

d)

(

**/**

**/**

**/**

**/**

 **1 mo.**

 **3-6 mo.**

 **1 mo.**

 **3-6 mo.**

Remarks

 **1-3 mo.**

 **Never**

 **1-3 mo.**

 **Never**

**REHABILITATION**

**8**

**.**

(

a)

Is patient a suitable candidate for further rehabilitation services? (i.e., cardiopulmonary program, speech therapy, etc.)...............................................

 **Yes**

 **No**

(

b)

Can present job be modified to allow for handling with impairment?.................................................................................................................................

 **Yes**

 **No**

**PATIENT’S JOB**

**ANY OTHER WORK**

(

c)

When could trial employment commence?.........................

**/**

**/**

 **Full-time**

**/**

**/**

 **Full-time**

Mo.

Day

Yr.

 **Part-time**

Mo.

Day

Yr.

 **Part-time**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| (d)  | Would vocational counseling and/or retraining be recommended?  |  |  **Yes**  |  |  **No**  |  |  |
|   |  |  |   |  |   | **( )**  | **―**  |

**PRINT** Physician’s Name Degree Specialty Telephone

Street Address

City

State or Province

Zip Code

Date

**/**

**/**

Signature

Tax Identification Number