



STRUCTURAL IRON WORKERS LOCAL NO. 1 WELFARE FUND

Disability Claim



Administered by:
Group Administrators, Ltd.
953 American Lane, Suite 100
Schaumburg, IL 60173

STATEMENT OF EMPLOYER

Employee's Name		I.D. No.	Unit or Div. No.
Date	By	Title	Telephone #
/ /	(Signature)	()	Area Code -

INSTRUCTIONS TO EMPLOYEE

- (1) This form is to be filed as soon as it appears that you will qualify for disability benefits.
- (2) Complete the **Statement Of Employee** and the **Authorization For Release Of Information** below.
- (3) Have your physician complete the **Attending Physician's Statement** on the reverse side.
- (4) Return Form to Group Administrators, Ltd. (*see address above*)

STATEMENT OF EMPLOYEE

Your name	Telephone Number	
	() -	
	Area Code	
Your occupation	Date of birth	Social Security No.
	/ /	- -
When did you become wholly unable to work? Date	Hour	A.M. P.M.
/ /		
Have you been continuously disabled since you became unable to work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, approximately when do you feel you will be able to resume work?		
If no, when did you again become able to work? Date	Hour	A.M. P.M.
/ /		
Is disability due to <input type="checkbox"/> accident or <input type="checkbox"/> sickness. (If accident, describe, including date and place.. If sickness, when did symptoms first appear?)		
Have you been hospital confined? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, when? From		
/ / To / /		
Name of hospital		
Address		
Did disability result from employment? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, amount of Workers' Compensation benefit\$		
Do you have disability insurance with other companies? <input type="checkbox"/> Yes <input type="checkbox"/> No. If yes, give names of companies and policy numbers:		
Name and address of your doctors during the past year ▼	Sickness or Injury ▼	Date Consulted ▼
These statements are true and complete to the best of my knowledge		
(Signature of Employee)		(Date)

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) When did symptoms first appear or accident happen? Mo. Day Year
(b) Date patient ceased work because of disability? Mo. Day Year
(c) Has patient ever had same or similar condition? Yes No
(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)
(b) Subjective symptoms
(c) Objective findings (including current X-rays, EKG's, Laboratory Data and any clinical findings)

3. DATES OF TREATMENT

- (a) Date of first visit Mo. Day Year
(b) Date of last visit Mo. Day Year
(c) Frequency Weekly Monthly Other (Specify)

4. NATURE OF TREATMENT (Including Surgery and medications prescribed, if any)

Blank line for treatment details

5. PROGRESS

- (a) Has patient Recovered Improved Unchanged Retrogressed
(b) Is patient 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

6. CARDIAC (If Applicable)

- (a) Functional capacity Class 1 (No limitation) Class 2 (Slight limitation) Class 3 (Marked limitation) Class 4 (Complete limitation)
(b) Blood Pressure (last visit) SYSTOLIC / DIASTOLIC

7. PROGNOSIS

- (a) Is patient now totally disabled? PATIENT'S JOB ANY OTHER WORK
(b) What duties of patient's job is he/she incapable of performing?
(c) Do you expect a fundamental or marked change in the future?
(d) If yes, when will/or did patient recover sufficiently to perform duties?
Remarks

8. REHABILITATION

- (a) Is patient a suitable candidate for further rehabilitation services?
(b) Can present job be modified to allow for handling with impairment?
(c) When could trial employment commence? PATIENT'S JOB ANY OTHER WORK
(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