STRUCTURAL IRON WORKERS LOCAL NO. 1 WELFARE FUND

Disability Claim

Administered by:
Group Administrators, Ltd.
20 North Martingale Rd., Suite 290
Schaumburg, IL 60173

STATEMENT OF EMPLOYER

Employee's Name | I.D. No. | Unit or Div. No.

Date / / | By (Signature) | Title | Telephone # ( ) – 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? ☐ **Yes** ☐ **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 ☐ **accident** or ☐ **sickness.** (If accident, describe, including date and place.. If sickness, when did symptoms first appear?)

Have you been hospital confined? ☐ **Yes** ☐ **No.** If yes, when? From / / To / /

Name of hospital ______ Address

Did disability result from employment? ☐ **Yes** ☐ **No.** If yes, amount of Workers' Compensation benefit .... **$** ______

Do you have disability insurance with other companies? ☐ **Yes** ☐ **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** *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)

(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)

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 (American Heart Association) ☐ **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

	PATIENT'S JOB		ANY OTHER WORK	
(a) Is patient now totally disabled?	☐ Yes	☐ No	☐ Yes	☐ No
(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?	☐ Yes	☐ No	☐ Yes	☐ No
(d) If yes, when will/or did patient recover sufficiently to perform duties?	☐ / /		☐ / /	
	☐ 1 mo.	☐ 3-6 mo.	☐ 1 mo.	☐ 3-6 mo.
Remarks ______	☐ 1-3 mo.	☐ Never	☐ 1-3 mo.	☐ Never

8. REHABILITATION

(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?	/ / (Mo. Day Yr.)	☐ Full-time ☐ Part-time	/ / (Mo. Day Yr.) ☐ Full-time ☐ 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