CLAIM FOR WEEKLY DISABILITY BENEFITS

PIPE TRADES INDUSTRY HEALTH AND WELFARE PLAN

P.O. BOX 3040 – TERRE HAUTE, INDIANA 47803
Telephone: - a/c 812-877-2581

Toll Free: 1-800-837-5678
FAX# 812-877-4542

THIS PART TO BE COMPLETED BY EMPLOYEE: YOUR LOCAL UNION NO**. _____**

Employee's Name _____ Identification No**. _____**

Address _____ Phone No. _____

DATE DISABILITY BEGAN _____

Was disability job related? _____

If disability is due to an accident, describe briefly what happened: _____

_____

Have you worked since sickness commenced? _____ If so, list dates worked:**_____**

Are you working now? _____ I certify that I was unable to work due to sickness or injury during the week(s) beginning

_____ and ending _____, and I further certify that I did not, or will not, receive compensation from my employer during this period.

In the case of a claim for the Weekly Disability Benefit, the week(s) for which you are claiming benefits must have passed. Multiple weeks may be included on a single claim form only when properly certified by the attending physician for a period prior to the date signed by the doctor. Benefits are payable on the basis of seven (7) day periods. In the case of sickness, you WILL NOT be paid for the first seven (7) days; however, a form properly certifying that you were under the care of a doctor during that week must be filed. Each form must be signed by a doctor who verifies that you were unable to work during the period for which you are claiming benefits. **ALL CLAIMS MUST BE FILED WITHIN ONE (1) YEAR OF THE FIRST DAY OF DISABILITY.**

SIGNED _____
(EMPLOYEE'S SIGNATURE)

DOCTOR'S REPORT

Not to be completed until Employee completes above section.

Physician's Name _____Phone No. _____

Address: _____

Date unable to work due to disability _____Date Released _____

Diagnosis of disability: _____

I certify the above named individual was unable to perform work of his trade during the week(s) designated above.

Date _____ SIGNED _____
(**PHYSICIAN'S SIGNATURE)**

DO NOT WRITE IN THIS SPACE – FOR OFFICE USE ONLY

Amount _____No. of weeks_____Payment No._____

Remarks_____