Plumbers & Fitters Local 101
Health and Welfare Fund
Disability Claim Form

Mail Claim Forms To:
JW TERRILL Benefit Administrators'
PO Box 6877
Chesterfield, MO 63006

PART I: MUST BE COMPLETED BY PARTICIPANT

Participant Name:	Social Security #:	Date of Birth:	Home Phone #:
Home Address:	City:	State:	Zip:

☐ Please check here if the address listed above is a new address.

First Date I Became Disabled:	Disability is due to (describe illness or injury):

Is Disability Work Related? ☐ Yes ☐ No

Have you applied for or are you receiving Social Security Disability (SSD) or Social Security Retirement benefits? ☐ Yes ☐ No

Have you applied for or are you receiving Unemployment Compensation? ☐ Yes ☐ No

HIPAA Certification and Authorization to Release Information

I hereby certify that the above information is true and correct to the best of my knowledge. I understand that a falsification or withholding of material facts may result in loss of benefits. For the purpose of determining eligibility for benefits and claim processing, I hereby authorize Benefit Consultants, Inc. to receive from and/or provide to medical practitioners, medically-related facilities, insurance companies or like organizations, trustees, or fund office personnel, information as to any physical or mental condition of myself or my covered dependents when the information is needed for treatment, payment or operations. I know that I have a right to receive a copy of this authorization. I agree a photographic copy is as valid as the original.

X_____ x_____

Participant's Signature Date

PART II: MUST BE COMPLETED BY PHYSICIAN

Patient's Name:	Date of First Visit for Current Condition:
Diagnosis and Concurrent Condition(s):	Is Sickness or Accident Related to or a result of Patient's Employment? ☐ Yes ☐ No
If hospitalized, name and address of facility:	If disability is due to pregnancy, expected date of delivery:

Was surgery performed? ☐ YES ☐ NO If yes, give date and type of surgery performed:

Considering the claimant's occupation, could claimant resume duties required of his usual occupation while continuing treatment?
☐ YES ☐ NO If no, please explain why:

Is patient still under your care: ☐ YES ☐ NO	Date Last Seen:	Next Appointment Date:

Patient was continuously disabled (unable to work) from: _____ to _____	Patient was released to work:
If off longer than the normal length of disability for this condition, please indicate the restrictions you have placed on this patient during recovery:	If still disabled, date patient is expected to be released to return to work:
Attending Physician:	Tax ID Number:
Address:	Phone:

Signature of Attending Physician:

PART III: TO BE COMPLETED BY FUND OFFICE and J.W. Terrill

Current Hourly Wage:	Average number of hours worked per week during the 36-month period immediately prior to onset of disability: