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

Send Claim Forms To:
Health & Welfare Fund Office
4600 46th Avenue
Rock Island, IL 61201
Fax: 309-788-8335

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 Unemployment Compensation? ☐ Yes ☐ No
Have you applied for or are you receiving Social Security Disability (SSD) or Social Security Retirement benefits? ☐ Yes ☐ No
I agree to reimburse the Plumbers & Pipefitters Local 101 Health & Welfare Fund should I receive any future Social Security Disability/Retirement Benefits related to this claim that The Fund has covered. ☐ Yes ☐ No _____ initials

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 Midwest Association of Health & Welfare Funds and/or Local 101 Health & Welfare Fund Office 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 PLUMBERS & FITTERS LOCAL 101 FUND OFFICE

The above listed Member has been covered under this Plan based on Active Hours (not Banked Hours) for at least one of the two calendar quarters immediately preceding commencement of the Disability. ☐ YES ☐ NO

Signature _____