UFCW Health & Welfare Fund of Northeastern Pennsylvania

EMPLOYEE DISABILITY CLAIM FORM

The employee must complete, sign, and return this form to the Fund Office. Notice of your claim must be filed within 7 days of commencement of disability or within 7 days following discharge from the hospital. Make sure your employer has sent the Employer Disability Claim Form to the Fund Office.

Information Received (This section is for Fund Office Use Only)

Date of Notice:	Notice Received Via: ☐ Call/Voicemail ☐ Mail ☐ Fax	
Caller Name:	Relationship:	Phone Number:

Contact Information

Full Name:			
Street Address:	City:	State:	Zip:
Social Security Number:	Date of Birth:		
Home Phone Number:	Mobile Number:	Fax Number:	
Email Address:			

Job Information

Job Title:	Facility/Location:	
Employer Name:	Contact Person:	Phone Number:
Description of Job Duties:		

Disability Information

Due to: ☐ Accident ☐ Illness ☐ Pregnancy	Is this related to a prior disability claim? ☐ Yes ☐ No	
If this is related to a prior disability claim, please provide details of prior disability:		
Pregnancy Information (if applicable)	Due Date:	
	If pregnancy complications, date began:	
Accident and Sickness Information (if applicable)	Date of Accident/Sickness:	
	Description of Accident/Sickness, including how and where it occurred:	
	Do you believe your Accident/Sickness is caused by or primarily related to your job? ☐ Yes ☐ No	
	If yes, please explain:	
Accident-Specific Information (if applicable) Ex. Auto Accident or Worker's Compensation Claim	Motor Vehicle Accident? ☐ Yes ☐ No	Claim Number:
	Work Related Accident? ☐ Yes ☐ No	
	Have you filed a Workers Compensation Claim? ☐ Yes ☐ No	Claim Number:
	Do you feel that any other parties are responsible for your accident? ☐ Yes ☐ No	
	Please explain:	
	Attorney Name:	Attorney Phone Number:

Walton Campus – 3031B Walton Road – Plymouth Meeting, PA 19462 Phone: 610-941-9400 – Fax: 610-941-9602

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Other Compensation

Have you worked for wages or profits since the date of your disability? ☐ Yes ☐ No
Are you receiving wage-loss benefits from another source? ☐ Yes ☐ No
If yes, please provide source:

Other Compensation for New York Residents

If you work in the state of New York, are hospital, surgical, or medical benefits or services provided under any other employer, union, student, association group play, or governmental program applicable to this claim? (If yes, please provide details below.) ☐ Yes ☐ No		
Policyholder Name:	Policy Number:	Policyholder Address:
Carrier Name:	Carrier Address:	

Doctor/Hospital Information

Treating Physician Name:			
Street Address:	City:	State:	Zip:
Phone Number:	Fax Number:		
Date First Seen by Physician:	Next Scheduled Appointment Date:		
Additional Appointment Dates:	Did your treating physician refer you to another doctor? ☐ Yes ☐ No		
Referral Information (if applicable)	Referral Physician Name:		
	Address:		
	Reason for Referral:		
Hospital Information (if applicable)	Hospital Name:		
	Address:		
	Date Admitted:	Date Discharged:	
Any other notes:			

Certification

Any person who knowingly, and with intent to defraud the Fund and/or other parties, files a statement or claim containing any materially false information, or conceals information, for the purpose of misleading the Fund and/or other parties concerning any fact material to this claim, commits a fraudulent insurance act which is a crime. I have read the above and verify that the information contained on this report is true and accurate.

Signature: _____ Date: _____

Authorization

I hereby authorize any physician, hospital, pharmacy, employer, organization, or insurance company, including any workers compensation carrier or motor vehicle insurance carrier under which I may receive any payment in connection with the injuries for which I am claiming disability benefits from the UFCW Health & Welfare Fund of Northeastern Pennsylvania (hereafter, "the Fund"), to release to the Fund, any and all information with respect to any injury or illness, including mental illness, drug/alcohol abuse, HIV-related, AIDS, or AIDS-related information to the extent permitted by law, medical history, consultations, prescriptions, treatments, or benefits and copies of all applicable records that may be requested for the purpose of processing a claim for benefits. The Fund is also authorized to disclose such information to any doctor or service, including case management, for the purpose of evaluating a claim for benefits.

Signature: _____ Date: _____