SEIU LOCAL 1 & PARTICIPATING EMPLOYERS HEALTH TRUST

DISABILITY CLAIM FORM

CLAIMS DEPARTMENT
111 E. WACKER DRIVE, 17TH FLOOR, CHICAGO, IL 60601
PHONE: (312) 233-8899

***TO BE COMPLETED BY EMPLOYEE*:** **Complete and sign this section. Take the form to your Physician and ask to have the bottom portion completed. Mail the original completed form to the Fund Office.**

Last Name **First Name**

Street Address **City** **State** **Zip**

( )
Phone Number **Date of Birth** **Alternate ID or SSN**

Employer **Date of Hire** **Building**

Briefly describe your illness or accident. If accident, describe when, where and how the accident occurred (use the back of this form if necessary).

Last date you were at work. **First date you returned to work.**

I hereby certify the foregoing statement, including any accompanying statements, are to the best of my knowledge and belief true, correct and complete. I hereby authorize any physician or hospital to furnish and disclose all known facts concerning this disability. I will reimburse the Trust for any overpayment made to me due to errors on this form.

X
Employee's Signature ***Date***

TO BE COMPLETED BY YOUR PHYSICIAN:

Diagnosis Code or Description **Chart Number**

Date First Consulted **Date of Surgery** **Date of Inpatient Hospitalization**

Date of Emergency Room Treatment **First Date Totally Disabled** **Date to Return to Work**

( )
Physician's Name **Group/Practice Association** **Phone Number**

Street Address **City** **State** **Zip**

Condition is due to: [ ] Illness [ ] Accident In your opinion, is the condition job related: [ ] Yes [ ] No

X
Physician's Signature ***Date***