

SEIU LOCAL 1 & PARTICIPATING EMPLOYERS HEALTH TRUST

INITIAL REPORT OF CLAIMS

NO BENEFITS CAN PAID UNLESS THIS FORM IS COMPLETED IN ITS ENTIRETY

Instructions:

This form is to be completed by the member, physician and employer. Complete member's section fully. Be sure to include/provide your Social Security Number and sign member's signature section.

Return completed form to:
SEIU Local 1 & Participating Employers Health Trust
111 E Wacker Drive, 17th Floor
Chicago, IL 60601
Phone: (312) 233-8899 Ext.5021 Fax: (312) 233-8839
Email: SEIUDisability@SEIU25.org

MEMBER COMPLETES THIS SECTION

Name of Member	ID Number (Begins with 825)	Home Phone	
Date of Birth	Social Security Number	Occupation	
Employer			
Home Address	City	State	Zip Code
Date Last Worked:	Date Resumed Work:		

FOR ALL CLAIMS:

Name of Sickness or Injury:	Date Accident Occurred or Sickness Began:	Date First Treated:
If Hospitalized, Name of Hospital:	Date Admitted:	Date Discharged:
Did someone intentionally cause this injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was injury due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did the accident happen on your property? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, address where accident occurred:	Was this due to an auto accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did injury or illness occur in the course of employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you filed this claim under Workmen's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you started a lawsuit related in any way to this injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you received any settlement, payment, recovery of benefits, including insurance company or policy, related in any way to this injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you hired an attorney to represent you regarding this claim? <input type="checkbox"/> Yes <input type="checkbox"/> No		

I hereby make claim for benefits and certify that the above statements are true and correct to the best of my knowledge and belief. I authorize the above-named institution or physician to release information concerning my enrollment, related records, and medical records to the SEIU Local 1 & Participating Employers Health Trust.

Member's Signature	Date
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Instructions

Attending Physician's Statement

Disability

To collect disability benefits, your doctor must complete sections 1, 2, 4, 5, 7, 8 and 9 and sign and date this form.

Attending Doctor's Statement

1. Diagnosis and concurrent conditions (if diagnosis code other than ICDA used, give name)

2. Is condition due to injury or sickness arising out of patient's employment? Is condition due to pregnancy? If Yes, approximate date pregnancy commenced

3. Date Admitted / Surgery

4. Date symptoms first appeared, or accident occurred	5. Date patient first consulted you for this condition	6. Has patient ever had same or similar condition? If yes, when and describe
7. Is patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	8. Patient was continuously totally disabled (unable to work) From _____ Thru _____	9. Date patient should be able to return to work, if still disabled

10. Does patient have other health coverage? If Yes, please identify

Yes No

Print Doctor's Name		Date
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Doctor's Signature and Address

Employer Sign off

To be completed and signed by the Employer to sign off on last day of work.

Employer Signature

Date of Last Day of Work

Date Returned to Work