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
200 East Randolph Street, Suite 1500
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? ☐Yes ☐No	Was injury due to an accident? ☐Yes ☐No	
Did the accident happen on your property? ☐Yes ☐No If no, address where accident occurred:	Was this due to an auto accident? ☐Yes ☐No	
Did injury or illness occur in the course of employment? ☐Yes ☐No	Have you filed this claim under Workmen's Compensation? ☐Yes ☐No	

Have you started a lawsuit related in any way to this injury/illness?
☐Yes ☐No

Have you received any settlement, payment, recovery of benefits, including insurance company or policy, related in any way to this injury/illness?
☐Yes ☐No

Have you hired an attorney to represent you regarding this claim?
☐Yes ☐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

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 thiscondition? ☐Yes ☐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

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