PLUMBERS, PIPEFITTERS & MES LOCAL UNION No. 392 FRINGE BENEFIT FUNDS
1228 Central Parkway, Room 100 · Cincinnati, OH 45202
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DISABILITY FORM

THIS FORM IS FOR EMPLOYEES WEEKLY DISABILITY BENEFITS ONLY. DO NOT USE IT TO FILE YOUR MEDICAL BILLS.

EMPLOYEE'S INFORMATION & STATEMENT

Name D.O.B. SS# (last four)

Address

Phone Email

Employer Last day worked Return to work date

Claim is due to: ☐ Sickness ☐ Accident/Injury	Are you disabled? ☐ Yes ☐ No

If claim is due to sickness, describe:

If claim is due to accident/injury, answer the following questions:

Date of accident: _____ Where did the accident happen? ☐ Work ☐ Other _____

How did the accident/injury occur?_____

Has there been or will there be a claim filed for this disability with the workers compensation carrier? ☐ Yes ☐ No

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment.

Signed (patient): Date:

ATTENDING PHYSICIAN'S STATEMENT

DATE OF FIRST TREATMENT FOR THIS DISABILITY:	DATES OF DISABILITY: FROM THRU	ESTIMATED RETURN TO WORK DATE:
DIAGNOSIS/ICD9 (INCLUDING COMPLICATIONS):		
WAS SURGERY PERORMED? ☐ YES ☐ NO DATE PERFORMED:	TYPE OF SURGERY/CPT CODE:	
IS PATIENT'S CONDITION DUE TO EMPLOYMENT? ☐ NO ☐ YES, PLEASE EXPLAIN:		
IS PATIENT TOTALLY DISABLED? ☐ YES ☐ NO, PLEASE EXPLAIN:		

PHYSICIAN'S NAME (PRINT)	DEGREE	PHONE #
ADDRESS		FED I.D. #
SIGNATURE		DATE