PIPE FITTERS UNION LOCAL No. 392
DISABILITY CLAIMS

1228 Central Parkway, Room 100 • Cincinnati, OH 45202 • (513) 241-0444 • Fax (513) 241-2028

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

EMPLOYEE'S STATEMENT

EMPLOYEE'S NAME	EMPLOYEE'S ADDRESS

TELEPHONE No.	SOCIAL SECURITY No.	DATE OF BIRTH	NAME OF EMPLOYER

LAST DAY WORKED	RETURN TO WORK DATE	ARE YOU DISABLED? ☐ YES ☐ NO	CLAIM IS DUE TO: ☐ SICKNESS ☐ ACCIDENT

IF SICKNESS, DESCRIBE:

IF ACCIDENT/INJURY ANSWER THE FOLLOWING QUESTIONS: BE SPECIFIC OR THE PROCESSING OF YOUR CLAIM MAY BE DELAYED.

DATE AND TIME OF ACCIDENT: DATE _____ TIME_____ ☐ A.M. ☐ P.M.

WHERE DID ACCIDENT HAPPEN: ☐ AT WORK ☐ OTHER _____

HOW DID ACCIDENT/INJURY OCCUR: GIVE ALL DETAILS:

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

DIAGNOSIS/ICD9 (INCLUDING COMPLICATIONS)

WAS SURGERY PERFORMED? ☐ YES ☐ NO DATE PERFORMED:	TYPE OF SURGERY/CPT CODE:

IS PATIENT'S CONDITION DUE TO EMPLOYMENT: ☐ NO ☐ YES, PLEASE EXPLAIN:	DATE OF FIRST TREATMENT FOR THIS DISABILITY:

☐ IS PATIENT TOTALLY DISABLED? ☐ IF NOT DISABLED, PLEASE EXPLAIN:

DATES OF HOSPITALIZATION: FROM _____ THRU _____ ☐ IN-PATIENT ☐ OUT-PATIENT

DATES OF DISABILITY: FROM _____ THRU _____

ESTIMATED RETURN TO WORK DATE _____

DATE	PHYSICIANS NAME (Print)	DEGREE	SIGNATURE:

ADDRESS	FED. I.D. #	PHONE #

TO BE COMPLETED BY ADMINISTRATIVE OFFICE:

CLAIM TYPE: NON-IND. ☐ W.C. ☐ CLASS CODE: JM ☐ APPR. ☐ MES. ☐ SUB-JM ☐ APPL. ☐

TARGET: PROCESSOR: DATE: