ALLIED BUILDING INSPECTORS

LOCAL 211 INTERNATIONAL UNION OF OPERATING ENGINEERS

WELFARE FUND

225 BROADWAY, 43RD FLOOR, NEW YORK, NY 10007

Phone: (212) 233-2690
Fax: (212) 962-2523

DISABILITY BENEFIT CLAIM

TO BE FULLY COMPLETED BY EMPLOYEE

Employee's Name _____ Date of Birth ____/____/____ (MO. / DAY / YEAR) ❑ Male ❑ Female

Home address _____ (NO & STREET / CITY / STATE / ZIP / PHONE NO.)

Dept. or Agency Address _____ Tel No. _____

Job Title _____ Bus. Phone _____

Annual Salary _____ Orig. Date Appld. to title _____ Social Security No. ____/____/____

Do you have paid sick leave? _____ How many days? _____

When did you first see Doctor? Date _____ Name of Doctor _____

Describe Illness _____

When did you become totally disabled so you could not work? Date _____ Date returned _____

IF CONFINED IN HOSPITAL

Name of Hospital _____

Address of Hospital _____

Date Admitted _____ Date Discharged _____

IF ILLNESS IS DUE TO ACCIDENT

Date of Accident _____ ❑ A.M. ❑ P.M. How did it happen _____

_____

_____

Did it happen at work? ❑ Yes ❑ No Did you file for Workmen's Compensation? ❑ Yes ❑ No

The above statements are true and complete to the best of my knowledge and belief and I hereby authorize any hospital or physician who has treated me to furnish any and all medical information to Allied Building Inspectors Local 211 Welfare Fund.

Date _____ Signature of Employee _____

Have your physician complete reverse side. Then file completed claim promptly with Welfare Fund Office.

PLEASE DO NOT WRITE IN SPACES BELOW - FOR OFFICE USE ONLY

Emp. Ver. _____ N.D.B Starts _____ Ver. by _____

Source _____

P.S.L. to _____ E.D.B. Starts _____ Date _____

Source _____

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ATTENDING PHYSICIAN'S STATEMENT

Patient's name _____ Age _____

Nature of sickness or injury (describe complication, if any) _____

_____

Did this sickness or injury arise out of patient's employment? ❑ Yes ❑ No

If "Yes," explain _____

_____

_____

Nature of surgical procedure, if any _____

Date performed _____ 20 _____

Where performed _____ if in hospital, ❑ in-patient ❑ out-patient

If Patient hospitalized, give name and address of hospital _____

_____

City _____ Date admitted ____/____/____ Date discharged ____/____/____
MO. DAY YEAR MO. DAY YEAR

Give dates of treatments:

Office _____

Home _____

Hospital _____

The patient has been continuously disabled (unable to work) from ____/____/____ to ____/____/____
MO. DAY YEAR MO. DAY YEAR

Remarks: _____

_____

_____

_____

Date _____ 20 _____ Signed _____ Degree
(ATTENDING PHYSICIAN)

Address _____ Phone _____