

DISABILITY CLAIM FORM

**International Union Of Operating Engineers Welfare Fund
Of Eastern Pennsylvania and Delaware
1375 Virginia Drive, Suite 102, Fort Washington Pennsylvania 19034
www.iuoe542funds.com 215-542-8211**

This Section To Be Completed By Member

1. Name _____ SS# _____
Address _____
2. Employer _____
3. If your claim is due to illness, state the nature of the illness _____
4. If your claim is due to an accident state:
 - a) When it happened _____
 - b) Where it happened _____
 - c) How it happened _____
 - d) Were you at work at the time of the accident. If so, for whom _____
5. State the last day you worked _____
6. State the date on which you became disabled & unable to work as a result of questions 3 & 4 _____
7. State the date the disability ended _____
8. State the date you returned to work _____
9. If still disabled, state the date you may be returning to work _____
10. Have you applied for unemployment compensation for any part of the period you claim you were disabled. (Answer yes or no; if the answer is yes, give dates) _____

Member's Signature _____ Date _____

This Section To Be Completed by Physician

1. Patient's Name _____ Date of Birth _____
2. Diagnosis (ICD9 Codes) _____
3. Is condition due to injury or sickness arising out of employment? Yes _____ No _____
4. Date patient first consulted you for this condition _____
5. Was patient hospitalized or was surgery required? Yes _____ No _____
 - a) If yes, please state date of admission or date of surgery _____
6. Is patient still under your care for this condition? Yes _____ No _____
7. Patient was continuously totally disabled (Unable to work) From _____ To _____
8. If still disabled, date patient should be able to return to work _____

Physician's Name (Print) _____ Degree _____

Street Address _____

City _____ State _____ Phone Number _____

Physician's Signature _____ Date _____