

WEEKLY DISABILITY CLAIM FORM

**International Union Of Operating Engineers Welfare Fund
Of Eastern Pennsylvania and Delaware
1375 Virginia Drive, Suite 102, Fort Washington Pennsylvania 19034
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This Section To Be Completed By Member

1. Name _____ SS# _____
2. Address _____
3. Daytime Phone Number _____
4. Employer _____
5. If your claim is due to illness, state the nature of the illness _____

6. 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 _____
7. State the last day you worked _____
8. State the date on which you became disabled & unable to work as a result of questions 5 & 6

9. State the date the disability ended _____
10. State the date you returned to work _____
11. If still disabled, state the date you may be returning to work _____
12. 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

Disabling Physician must be an M.D. or a D.O.

Patient's Name _____ Date of Birth _____

1. Diagnosis (ICD 10 Codes) _____
2. Is condition due to injury or sickness arising out of employment? Yes _____ No _____
3. Date patient first consulted you for this condition _____
4. Was patient hospitalized or was surgery required? Yes _____ No _____
a) If yes, please state date of admission or date of surgery _____
5. Type 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 _____