



Plumbers & Pipefitters Local 520

PO Box 1889

Troy, MI 48099-1889

(833) 263-5750



(717) 565-1101

www.ua520benefits.org

Accident and Sickness Claim Form

Note: You must answer all questions completely or your application for benefits will be denied

TO BE COMPLETED BY THE EMPLOYEE:

EMPLOYEE'S NAME (PLEASE PRINT)

ADDRESS

CITY

STATE

ZIP

DATE OF BIRTH

SOCIAL SECURITY #

PHONE NUMBER

COMPLETE ONLY IF CLAIM CAUSED BY INJURY	DATE OF INJURY, HOUR (AM/PM), WHERE DID ACCIDENT OCCUR?	
	HOW DID ACCIDENT HAPPEN?	
COMPLETE ONLY IF CLAIM CAUSED BY ILLNESS	HAS THIS CONDITION BEEN TREATED BEFORE?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	WHAT DATE WAS THE PHYSICIAN FIRST CONSULTED?	
COMPLETE FOR ANY DISABILITY CLAIM	FIRST DATE YOU WERE UNABLE TO WORK	
	DATE YOU RETURNED TO WORK	
	IF YOU HAVE NOT RETURNED, DATE YOU EXPECT TO RETURN	
	IS DISABILITY THE RESULT OF EMPLOYMENT?	<input type="checkbox"/> YES <input type="checkbox"/> NO

HAVE YOU FILED, OR DO YOU INTEND TO FILE, A CLAIM FOR BENEFITS UNDER WORKMEN'S COMPENSATION ACT? YES NO

HAVE YOU RECEIVED UNEMPLOYMENT COMPENSATION BENEFITS SINCE YOUR LAST DAY OF WORK? YES NO

IF SO, FOR WHAT PERIOD OF TIME? FROM: _____ TO: _____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I HEREBY AUTHORIZE ALL DOCTORS, HOSPITALS OR OTHER INSTITUTIONS RENDERING CARE AND TREATMENT TO FURNISH THE PLUMBER AND PIPEFITTERS LOCAL 520 HEALTH AND WELFARE FUND WITH FULL INFORMATION REGARDING TREATMENT RENDERED, INCLUDING COPIES OF THEIR RECORDS. I ALSO AUTHORIZE ANY UNION TRUST FUND, EMPLOYER OR INSURANCE CARRIER TO FURNISH THE PLUMBER AND PIPEFITTERS LOCAL 520 HEALTH AND WELFARE FUND WITH INFORMATION REGARDING BENEFITS TO WHICH I OR ANY OF MY DEPENDENTS MAY BE ENTITLED TO.

DATE

EMPLOYEE'S SIGNATURE

PART A	TO BE COMPLETED BY PATIENT (EMPLOYEE)			
PATIENTS NAME		DATE OF BIRTH		SOCIAL SECURITY NUMBER
PATIENTS ADDRESS		CITY	STATE	ZIP
CLAIMANTS ASSIGNMENT (READ BEFORE SIGNING)				

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.

SIGNATURE OF CLAIMANT

DATE

PART B	ATTENDING PHYSICIAN'S STATEMENT			
1. DIAGNOSIS AND CURRENT CONDITIONS (IF DIAGNOSIS CODE OTHER THAN ICDA USED, GIVE NAME)				
2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF A PATIENT'S EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				
3. IS CONDITION DUE TO PREGNANCY?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	IF YES, DATE PREGNANCY BEGAN:
4. REPORT OF SERVICES (OR ATTACH OFFICE NOTES) (IF SUBSEQUENT FORM, ONLY SHOW NEW DATES OF SERVICE)				
DATES OF SERVICE	PLACE OF SERVICE	TYPE OF SERVICE		

5. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED	6. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION
7. HAS PATIENT EVER HAD THE SAME OR A SIMILAR CONDITION BEFORE? IF YES, PLEASE DESCRIBE	8. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
9. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK)	
FROM	THRU
10. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO FULL DUTIES	
11. IF CONTINUING DISABILITY, DATE OF NEXT EVALUATION	

DATE

PHYSICIAN'S SIGNATURE

PHYSICIAN'S NAME (PLEASE PRINT)

DEGREE

ADDRESS

CITY

STATE

ZIP

PHONE NUMBER

FAX NUMBER