BAC Local Union 15 Welfare Fund

DISABILITY CLAIM - SUPPLEMENTARY

This form MUST be completed on or about: _____

PART A: TO BE COMPLETED BY PATIENT (INSURED)

1. Personal Information:

Name: _____ Social Security Number: _____

Date of Birth: _____ / _____ / _____

Address: _____

City: _____ State: _____ Zip Code: _____

2. Authorization to release information:

I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment. I also make claim for benefits and certify that the statements under Part A are true and complete to the best of my knowledge.

Signature of Insured: _____ Date: _____ / _____ / _____

3. State last day worked because of disability: _____ / _____ / _____

4. On what date were or will you be able to perform full-time work: _____ / _____ / _____

5. If injured, how and where did the accident occur? _____

6. Did injury occur in the course of employment? ☐ Yes ☐ No

7. Was this due to a motor vehicale accident? ☐ Yes ☐ No

8. Have you or do you intend to file this claim under Workmen's Compensation? ☐ Yes ☐ No

9. Are you now engaged in the duties of any occupation or endeavor for wages, profits or compensation? ☐ Yes ☐ No

PART B: ATTENDING PHYSICIAN'S STATEMENT

10. Diagnosis and concurrent conditions: _____

11. Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other: _____

12. Is patient totally disabled from any occupation? ☐ Yes ☐ No

Date patient became totally disabled: _____ / _____ / _____

13. Is patient totally disabled from his/her regular occupation? ☐ Yes ☐ No

Date patient became totally disabled: _____ / _____ / _____

14. On what date will the patient be able to resume normal activities and return to work? _____ / _____ / _____

15. Attending Physician's Information:

Physician's Name: _____ Physician's Signature: _____

Degree: _____ Date: _____ / _____ / _____

Address: _____

City: _____ State: _____ Zip Code: _____

16. Remarks:

_____

_____

_____

Return completed forms to:

BAC Local Union 15 Welfare Fund
Attn: Claims Department
PO Box 909500
Kansas City, MO 64190-9500
(816)777-2668 | Fax (816)756-3659