

# SEIU LOCAL 1 & PARTICIPATING EMPLOYERS HEALTH TRUST

## DISABILITY CLAIM FORM

CLAIMS DEPARTMENT  
111 E. WACKER DRIVE, 17<sup>TH</sup> FLOOR, CHICAGO, IL 60601  
PHONE: (312) 233-8899

**TO BE COMPLETED BY EMPLOYEE:** Complete and sign this section. Take the form to your Physician and ask to have the bottom portion completed. Mail the original completed form to the Fund Office.

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

( )  
\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Alternate ID or SSN

\_\_\_\_\_  
Employer

\_\_\_\_\_  
Date of Hire

\_\_\_\_\_  
Building

\_\_\_\_\_  
Briefly describe your illness or accident. If accident, describe when, where and how the accident occurred (use the back of this form if necessary).

\_\_\_\_\_  
Last date you were at work.

\_\_\_\_\_  
First date you returned to work.

\*I hereby certify the foregoing statement, including any accompanying statements, are to the best of my knowledge and belief true, correct and complete. I hereby authorize any physician or hospital to furnish and disclose all known facts concerning this disability. I will reimburse the Trust for any overpayment made to me due to errors on this form.\*

X  
\_\_\_\_\_  
*Employee's Signature*

\_\_\_\_\_  
*Date*

**TO BE COMPLETED BY YOUR PHYSICIAN:**

\_\_\_\_\_  
Diagnosis Code or Description

\_\_\_\_\_  
Chart Number

\_\_\_\_\_  
Date First Consulted

\_\_\_\_\_  
Date of Surgery

\_\_\_\_\_  
Date of Inpatient Hospitalization

\_\_\_\_\_  
Date of Emergency Room Treatment

\_\_\_\_\_  
First Date Totally Disabled

\_\_\_\_\_  
Date to Return to Work

\_\_\_\_\_  
Physician's Name

\_\_\_\_\_  
Group/Practice Association

( )  
\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

Condition is due to: [ ] Illness [ ] Accident In your opinion, is the condition job related: [ ] Yes [ ] No

X  
\_\_\_\_\_  
*Physician's Signature*

\_\_\_\_\_  
*Date*