National Roofers Union & Employers Joint Health & Welfare Fund

DISABILITY CLAIM - SUPPLEMENTARY

This form MUST be completed on or about: _____

Group Number: **F61**

PART A: *TO BE COMPLETED BY PATIENT (INSURED)*

1. Personal Information

Your Name: _____

Social Security Number: _____

Date of Birth: _____

Address: _____

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:

_____ / _____ / _____

month day year

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

_____ / _____ / _____

month day year

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

6. Did injury occur in the course of employment?

☐ Yes ☐ No

7. Have you or do you intend to file this claim under Workmen's Compensation?

☐ Yes ☐ No

8. 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*

9. Diagnosis and concurrent conditions:

10. Frequency of visits:

☐ Weekly ☐ Monthly ☐ Other: _____

11. Is patient totally disabled from any occupation?

☐ Yes ☐ No

Date patient became totally disabled: _____ / _____ / _____

month day year

12. Is patient totally disabled from his/her regular occupation?

☐ Yes ☐ No

Date patient became totally disabled: _____ / _____ / _____

month day year

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

_____ / _____ / _____

month day year

14. Attending Physician's Information:

Physician's Name: _____

Physician's Signature: _____

Degree: _____ Date: _____

Address: _____

15. Remarks:

_____

To be completed and signed by the Employer to sign off on last day of work.

Employer Signature Signed	Date of last day of work

Return completed forms to:

National Roofers Union & Employers Joint Health & Wefare Fund, Attn: Claims Department, 3001 Metro Drive – Suite 500, Bloomington, MN 55425

Phone: (952) 854-0795, Toll Free: (800) 622-8780, Fax: (952) 854-1632