APPLICATION FOR DISABILTY BENEFIT

Plumbers Local Union No.68 Health & Welfare Fund
P.O. Box 8726
Houston, Texas 77249
(713) 869-2592 or Fax (713) 862-4877
Email: benefits@plu68.com

You must complete this form in its entirety and return it to the address above.

Name _____ ID # _____

Phone _____ Email Address _____

Address _____ City/State/Zip _____

Employer _____ Employer's Phone _____

Nature of Illness or Injury in Detail _____

When did you become wholly unable to work? (Date and Time) _____

Where you at work when the accident occurred ☐ YES ☐ NO

If yes, was the disability caused by a work related accident? ☐ YES ☐ NO

Have you filed a claim with Workers Compensation for the disability? ☐ YES ☐ NO If yes, indicate start date _____

Are you currently receiving or have filed for unemployment benefits? ☐ YES ☐ NO If yes, indicate start date _____

Please provide your treating physician's information so that we may have them certify your disability.

Physician's Name _____

Address _____ City/State/Zip _____

Phone _____ **Physician's Fax Number (Required)** _____

Authorization For Release of Information: In order to process a claim for benefit, I authorize any physician, hospital, or other medical provider to release to the Plumbers Local Union #68 Health & Welfare Fund any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A copy of this authorization shall be considered as effective and valid as the original.

Date _____ Participant's Signature _____

Physician-Please Fill Out Part B
(See reverse side)

HEALTH INSURANCE CLAIM – GROUP MEDICAL

PART B ATTENDING PHYSICIAN'S STATEMENT

Name of Subscriber

Subscriber I.D. #

1. DIAGNOSIS AND CONCURRENT CONDITIONS
(IF DIAGNOSIS CODE OTHER THAN ICDA* USED, GIVE NAME)

2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? ❑ YES ❑ NO

PREGNANCY? ❑ YES ❑ NO

IF YES, APPROXIMATE DATE PREGNANCY COMMENCED.

DATE: _____

3. REPORT OF SERVICES (OR ATTACH ITEMIZED BILL) (IF PREVIOUS FORM SUBMITTED TO THIS CARRIER, YOU NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT)

DATE OF SERVICES	PLACE OF SERVICES †	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE - IF USED (IF CODE OTHER THAN CPT* USED, GIVE NAME)

† O – DOCTOR'S OFFICE IH – INPATIENT HOSPITAL NH – NURSING HOME
H – PATIENT'S HOME OH – OUTPATIENT HOSPITAL OL – OTHER LOCATIONS
*ICDA – INTERNATIONAL CLASSIFICATION OF DISEASES
**CPT – CURRENT PROCEDURAL TERMINOLOGY (CURRENT EDITION)

4. DATE SYMPTOMS FIRST APPEARED OR SIMILAR CONDITION.

5. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION.

6. PATIENT EVER HAD SAME OR SIMILAR CONDITION?.
❑ YES ❑ NO IF "YES" WHEN AND DESCRIBE

7. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?
❑ YES ❑ NO

8. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED
(UNABLE TO WORK)
FROM _____ THRU _____

9. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK.

10. DOES PATIENT HAVE OTHER HEALTH COVERAGE?
❑ YES ❑ NO IF "YES" PLEASE IDENTIFY

11. I DO NOT ACCEPT ASSIGNMENT ❑

*INDIVIDUAL PRACTITIONERS – SS#
ALL OTHERS – EMPLOYER I.D. #
MUST BE FURNISHED UNDER AUTHORITY OF LAW.

I HEREBY APPROVE RELEASE OF INFORMATION PERTAINING TO HOSPITAL CONFINEMENT OF THIS PATIENT TO U.A. PLUMBERS LU #68 GROUP PROTECTION PLAN ON AUTHORIZATION OF THE INSURED.

DATE | PHYSICIAN'S NAME (PRINT) | SIGNATURE | DEGREE | TELEPHONE

STREET ADDRESS | CITY OR TOWN | STATE OR PROVINCE | ZIP CODE