PLUMBERS & PIPEFITTERS LOCAL NO. 520 HEALTH AND WELFARE FUND

P.O. Box 6480, Harrisburg, PA 17112 717-671-8551 - Fax (717)-671-8602

PARTI CI PANT'S STATEMENT

DISABILITY CLAIM FORM

	Date of Birth		
Social Security Number	Home Phone #		
Address			
Nature of Sickness or Injury			
If Accident, when and where did accident happen?			
		Did your disability arise out of your employment?	Yes No (Check One)
		Will this claim for benefits be made under any other policy	or with any other CompanyYesNo
		If yes – Company name	
		payable under this or any other plan providing benefits or services. I understand that in signing this authorization I waive the right for such information to be privileged. A photostatic copy of this authorization shall be considered as effective and valid as the original. I certify that the information given by me in support of this claim is true and correct. Date Participant's Signature PHYSICIAN'S STATEMENT	
	ICD-9 Code		
Has patient been hospitalized for present disability?	Yes No If Yes, give dates and names of:		
Has patient been hospitalized for present disability?	Yes No If Yes, give dates and names of: From To		
Has patient been hospitalized for present disability? Hospital Date of first treatment	Yes No If Yes, give dates and names of: From To Date of most recent treatment		
Has patient been hospitalized for present disability? Hospital Date of first treatment Next visit schedule for	Yes No If Yes, give dates and names of: From To Date of most recent treatment Frequency of treatments		
Has patient been hospitalized for present disability? Hospital Date of first treatment Next visit schedule for The patient has been continuously disabled (unable to wor	Yes No If Yes, give dates and names of: From To Date of most recent treatment Frequency of treatments		
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Has patient been hospitalized for present disability? Hospital Date of first treatment Next visit schedule for The patient has been continuously disabled (unable to wor From If still disabled, when should patient be able to return to w If any change in previous diagnosis prolonging disability, p Remarks: Physician's Name (Please print)	Yes No If Yes, give dates and names of: From To Date of most recent treatment Frequency of treatments To vork? please explain		

520 Disb Claim Form 2010 02/2010