# WEEKLY ACCIDENT AND SICKNESS
# NON-OCCUPATIONAL DISABILITY BENEFIT CLAIM FORM
## PLUMBERS AND PIPEFITTERS MEDICAL FUND

7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046 • 1-800-741-9249

**INSTRUCTIONS:** This form is to be used to submit a claim for the weekly accident and sickness disability income benefits which are payable when an employee is unable to work on account of a non-occupational illness or injury. The completed form should be submitted to the Medical Fund office at the address indicated above. To avoid having your claim returned PLEASE BE SURE ALL INFORMATION IS CORRECT AND COMPLETE.

## TO BE COMPLETED BY MEMBER

1. Member's Name _____ Social Security No. _____
*Last* *First* *Initial*
Date of Birth _____
Home Telephone No. _____

2. Home Address _____
*Street Number and Name* *City* *State and Zip Code*

3. Name of Employer _____

4. Describe symptoms of illness or injury _____

5. Was condition a result of an accidental injury? ☐ Yes ☐ No If Yes, complete the following:

Date of injury _____ Place of injury _____

Describe how injury occurred _____

6. Date you were first unable to return to work _____ Are you still unable to work because of your disability? ☐ Yes ☐ No

If No, give date you returned or were able to return to work _____ If Yes, when do you expect to return to work _____

7. Was illness or injury caused by employment? ☐ Yes ☐ No If Yes, do not submit claim to Medical Fund. Submit to your employer's worker's compensation insurance company.

I certify that the above information is correct and that I have coverage with the Medical Fund. I apply for weekly accident and sickness benefits under this coverage with the understanding that these benefits are payable only during the period that I am unable to work due to a non-occupational injury or illness. I agree to notify the Medical Fund Administrative Office of the date I return or am able to return to work if such date is not indicated above. I further agree if I receive payments for any period after the date of my recovery, I will return the payments to the Medical Fund.

Date _____ Signature of Member _____

## TO BE COMPLETED BY PHYSICIAN

1. Diagnosis and concurrent conditions _____ Diagnosis Code _____

2. Date symptoms first appeared or accident happened _____

3. Date patient first consulted you for this condition _____

4. Has patient ever had same or similar condition? ☐ Yes ☐ No
If Yes, when and describe: _____

5. Is patient still under your care for this condition?
☐ Yes ☐ No

6. Dates patient was continuously disabled (Unable to work)
From: _____ Thru: _____

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

8. Physician's Name *(print)* _____

9. Physician's Telephone No. _____

10. Physician's Address _____
*Street Number and Name* *City* *State and Zip Code*

Date _____ Signature of Physician _____