DISABILITY PROOF OF CLAIM AND PHYSICIANS STATEMENT

I.U.P.A.T. District Council No. 51 Health Fund

Zenith American Solutions - 3 Gateway Center, 401 Liberty Ave., Ste 1200, Pittsburgh PA 15222-1024

INSTRUCTIONS:

1. Complete Section I and either Section II (work related) or Section III (non work-related)
2. Have your physician complete Section IV and submit the completed form to the Medical Fund.
3. If injury is work related, submit copy of worker's compensation award and dates of payments (i.e., check copies).

SECTION I (To be completed by Employee – Please Print or Type)

1. Name of Employee Local No.	5. Employer
2. Employee's Address	6. Employer's Address
3. Home Telephone No:	7. Employer Telephone No.
4. Social Security No:	8. Employee Date of Birth:

SECTION II (Complete this section only if injury or illness occurred on the job)

9. Date of Injury:________________, (Year)_______ Day of Week:____________ Hour of day______A.M. ______P.M.

10. Date disability began:____________(Year)_______ Hour of Day:___A.M. _____P.M. Were you paid in full for this day?__________________________

11. When did you or foreman first know of injury?____

12. Name of foreman:____

13. Describe fully how accident occurred, and state what employee was doing when injured:____

____

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14. Last Day Worked:_____________________ Job Site:____

15. Name and Address of Physician who first treated you:	16. If hospitalized, give name and address of Hospital:

SECTION III (Complete for non-job related injury or illness)

17. Nature of Illness or Injury:	18. Last Day Worked:
19. If Accident (Describe)	

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, government agency or other organization, institution or person that has any record of knowledge of me or my health, to give any such information to the I U P AT District Council 51 Health Fund. A photostat of this authorization shall be as valid as the original. It shall remain effective for one year from the date of authorization.

Date:	Employee Signature:

SECTION IV (To be completed by attending physician)

1. Diagnosis and concurrent conditions (if diagnosis code other than ICOA used, give name):	
2. Date symptoms first appeared or accident happened:	3. Date patient first consulted you for this condition:
4. Patient ever had same or similar condition: ___Yes ___No If "yes", when and describe:	5. Patient still under your care for this condition? ____Yes ____No
5. Patient was continuously totally disabled (Unable to Work) From: Thru:	7. If still disabled, date patient should be able to return to work.

Date	Physician's Name (Print)	Signature	SS.#	Telephone:

Street Address:	City or Town	State	Zip Code

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