Plumbers & Steamfitters Local 486
Medical Fund

P.O. Box 1064
Sparks, Maryland 21152-1064
Toll Free Telephone (888) 494-4443
www.associated-admin.com

WEEKLY ACCIDENT AND SICKNESS BENEFITS CLAIM FORM

PARTICIPANT'S STATEMENT

First Name (**Please Print**) Middle Last Name Member's Social Security Number

Street Address City State Zip Code

Nature of Disability (If injury, also state how, when, and where it occurred)

Date Disability Started (MM/DD/Year) Last Day Worked (MM/DD/Year)

Most Recent Employer Local Union

Are you currently receiving Workers' Compensation Benefits? Yes No

If the answer is "yes," please indicate dates that you started receiving these benefits. _____

I authorize the release of any medical information necessary to process this claim.

Member's Signature

DOCTOR'S STATEMENT

Patient's First Name **(Please Print)** Middle Last Name

Gender: Male Female Diagnosis: _____

Is surgery indicated? Yes No Type of Surgery: _____ Date of Surgery: _____

Outpatient: Yes No Inpatient: Yes No If yes, admitted on: _____ Discharged on: _____

Enter dates for the following:

a) Date patient was unable to work due to this disability: _____
b) Date patient was first seen for treatment for this disability: _____
c) Date of your most recent treatment for this disability: _____
d) Date patient will be able to return to work (subject to revision): _____
e) Maternity – Expected date of delivery: _____

In your opinion, is this disability the result of injury occurring during the course of employment or from occupational disease? Yes No Date: _____

Remarks: _____

Physician's Name Physician's Signature Physician's Phone Number

Street Address City State Zip Code

(See instructions on reverse side)

READ THESE INSTRUCTIONS CAREFULLY BEFORE YOU COMPLETE YOUR CLAIM FOR DISABILITY BENEFITS. FILE YOUR CLAIM PROMPTLY.

1. Use this form only if you become sick or disabled while eligible for benefits.
2. You must complete all items in the "Participant's Statement" and mail or take the entire form to your physician as soon as possible. Be accurate in completing the form; check all dates.
3. Be sure to sign and date your claim. If you cannot sign this claim form, your representative may sign on your behalf. In that event, the representative's relationship to you and his/her address should be noted under his/her signature.
4. Do not mail this claim unless your doctor has completed and signed the "Doctor's Statement." If possible, have it completed while you are in the doctor's office.
5. Your benefits will begin as soon as a complete and accurate statement is received by the Fund Office.
6. Disability benefits are not payable for any disability caused by willful intention to bring about an injury or sickness or resulting from an injury or sickness sustained in the commission of an illegal act.
7. Disability benefits are not payable for any period during which you:
    A. Become sick or disabled prior to the time you are eligible.
    B. Receive, or are eligible to receive, unemployment insurance benefits from any state.
    C. Receive, or are entitled to receive, benefits under any Workers' Compensation legislation or similar legislation.