DISABILITY STATEMENT OF CLAIM

MAIL TO:
SOUTHEAST LABORERS HEALTH FUND
P.O. Box 1449
Goodlettsville, TN 37070-1449

Participants Name: ______________________________

Social Security Number: ______________ Date of Birth: ______________

Address: ______________________________
____

Participant's Current or Last Employer: ______________________________

Local Union No: __________

Complete if Disability is due to an Accident:

1. Date of Accident: ______________________________
2. Location of Accident: ______________________________
3. Give Details of Accident: ______________________________

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Complete if Disability is due to an illness:

1. Date Symptoms First Appeared: ______________________________
2. Nature of Illness: ______________________________

Is this Disability Due to your Occupation? Yes ____ No ____

Is this Disability Covered by any Workers' Compensation or Occupational Disease Law? Yes _____ No _____

First Full Day Unable to Work: ______________________________

Date Resumed Work: ______________ Or
Date Expected to Resume Work: ______________
Undetermined

Did you receive any wages during your period of Disability? Yes _______ No _______

I certify that the above information is true and correct. I hereby authorize all doctors, hospitals, or other institutions rendering care and treatment to furnish the Southeast Laborers Health Fund with full information regarding treatment rendered (including copies of records).

______________________________ ______________________________
Signature Date

ATTENDING PHYSICIAN MUST COMPLETE REVERSE SIDE

ATTENDING PHYSICIAN'S STATEMENT

Participant's Name: ______________________ SSN: ______________________

Diagnosis and Concurrent Conditions:

Primary Diagnosis: ______________________ ICD Code: ______________

Secondary Diagnosis: ______________________ ICD Code: ______________

______________________ ICD Code: ______________

______________________ ICD Code: ______________

Is Condition due to injury or illness arising out of patient's employment: Yes _____ No _____

Date Symptoms first appeared or accident occurred: ______________________

Date patient first consulted you for this condition: ______________________

Has patient ever had the same or similar condition: Yes _______ No _______

If "Yes" when an describe: ______________________

Is patient still under your care for this condition: Yes _______ No _______

For purposes of this form, "Totally Disabled" means that the Eligible Employee is prevented by an accident or illness from performing each and every duty of his occupation or employment.

Patient was continually Totally Disabled during the period from __________ through __________

If still disabled, the patient should be able to return to his regular employment on ______________

Date ______________ Signed ______________________ M. D.
(Attending Physician)

Soc. Sec. No. ______________ Address ______________________

or Tax I.D. No. ______________ ______________________

Phone ______________________

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SLlossofincome