RETURN THIS FORM TO:

UNITED FOOD & COMMERCIAL WORKERS
UNION-EMPLOYER HEALTH & WELFARE FUND
9199 Market Place, Ste. 1 • Broadview Heights, Ohio 44147
Telephone (216) 241-2828 WATS 1-800-241-2828

TO AVOID UNDUE DELAY COMPLETE ALL REQUIRED AREAS OF INFORMATION. YOUR CLAIM CANNOT BE PROCESSED UNLESS THIS FORM IS COMPLETED IN FULL.

RETURN IMMEDIATELY

STATEMENT OF CLAIM

Completed Form Can Be emailed to: hwforms@ufcw880funds.com

TO BE COMPLETED BY EMPLOYER

NOTICE: It is illegal to file a false or fraudulent claim or to knowingly help someone else file one. You may be fined or sent to prison for doing so. You may also be required to pay civil damages

name of employee

first full day unable to work ______ date ______

☐ RESUMED WORK
☐ EXPECTED TO RESUME
☐ TERMINATED

☐ No HAS EMPLOYEE WORKED AT ALL BETWEEN THE ABOVE DATES

☐ Yes, from ______ (date) to ______ (date)

name of employer

address

city – state – zip code ______ telephone number

signed (must be the person responsible for employment records)

title ______ date

TO BE COMPLETED BY EMPLOYEE

name

home phone number ______ birth date

HAVE YOU RETURNED TO WORK?

Yes ☐ GIVE DATE YOU RETURNED TO WORK ______

No ☐ GIVE DATE YOU EXPECT TO RETURN TO WORK ______

social security number

address

city – state – zip code

WE NEED THIS SECTION COMPLETED IN ORDER TO FURTHER CONSIDER YOUR CLAIM. All answers are true and correct to the best of my knowledge. I hereby authorize any physician, surgeon, practitioner or other person, any hospital, including veterans administration or governmental hospital, any medical service organization, any insurance company, or any other institution or organization to release to each other any medical or other information acquired, including benefits paid or payable, concerning this or other disabilities. A photostat of this authorization shall be as valid as the original.

signature ______ date signed

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

IF DISABLED AFTER ______ (date)

1. PRIMARY DIAGNOSIS ______
2. COMPLICATING FACTORS ______
3. DATE OF FIRST TREATMENT ______
4. GIVE DATES OF TREATMENT SINCE ______ { HOME ______ / OFFICE ______ / HOSPITAL ______ }
5. PATIENT WAS HOUSE ☐ HOSPITAL ☐ CONFINED FROM ______ THROUGH ______
6. THE PATIENT HAS BEEN CONTINUOUSLY DISABLED (unable to work) FROM ______ THROUGH ______ IF UNKNOWN, PLEASE ESTIMATE
7. DATE PATIENT WILL BE ABLE TO RETURN TO WORK OR FULL NORMAL ACTIVITIES ______
8. IF DISABILITY EXTENDED FROM PREVIOUS ESTIMATE, PLEASE EXPLAIN ______

please print or type attending physician's name ______ degree

address

city – state – zip code ______ phone

claim number

INDIVIDUAL PRACTITIONERS S.S. #			
ALL OTHERS — EMPLOYER I.D. #			

MUST BE FURNISHED UNDER AUTHORITY OF LAW

attending physician's signature ______ date

FOR ADDITIONAL SICK-PAY BENEFITS TO BE PAID, THIS FORM MUST BE COMPLETED AND RETURNED TO OUR OFFICE.

ATTENDING PHYSICIAN'S SUPPLEMENTARY REPORT

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