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 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 FOR SHORT TERM DISABILITY

TO BE COMPLETED BY EMPLOYER

Member to complete Highlighted portions
Return by Email to: hwforms@ufcw880funds.com

name of employee

NO ☐ YES ☐ WAS THE EMPLOYEE COVERED UNDER THIS PLAN ON DATE OF DISABILITY? ..... If "yes", effective date of insurance

date employed

occupation and employment status on date of disability ☐ FULL TIME ☐ PART TIME

$ ..... basic weekly earnings

NO. OF HOURS AVG. WEEKLY.....

HOURLY RATE .....

first full day unable to work date ☐ TERMINATED ☐ RESUMED WORK ☐ EXPECTED TO RESUME

name of employer

address

city—state—zip code telephone number

signed

title date

TO BE COMPLETED BY EMPLOYEE

please print last name first middle

home address

city—state—zip code

date of birth social security number

telephone number

first date you were unable to work at time (am-pm)

date expect to resume work

DESCRIBE DISABILITY:

The above 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.

employee's signature date

PLEASE ALSO SIGN AUTHORIZATION TO RELEASE INFORMATION ON REVERSE SIDE OF FORM

THE ATTENDING PHYSICIAN MUST COMPLETE THE REVERSE SIDE OF THIS FORM

name of employer (firm name)

occupation

primary job duties

HOURS

IN AN EIGHT HOUR WORK DAY. REQUIRED TO BE IN THE FOLLOWING POSITION

Sitting ..... Hrs. Standing ..... Hrs. Walking ..... Hrs.

Heaviest weight you had to lift ..... lbs. object .....

How many times in a work day .....

Heaviest weight you had to carry ..... lbs. object .....

How many times in a work day .....

Reaching above shoulder YES ☐ NO ☐

Bending
How often in a work day .....

Stooping
How often in a work day .....

Machinery or equipment you were required to use

Environmental or physical factors affecting your pregnancy

Explain how your disability prevents you from performing any of the above job description .....

PART A — TO BE COMPLETED BY PATIENT (MEMBER)

PATIENT'S NAME AND ADDRESS | DATE OF BIRTH

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment.

SIGNED (PATIENT, OR PARENT IF MINOR)

PART B — ATTENDING PHYSICIAN'S STATEMENT

I. DIAGNOSIS: METHOD OF DELIVERY:

II. HISTORY:

LMP ___/___/___ Para _____ B/P _____ Date ___/___/___

EDD ___/___/___ Gravida _____ Ht. _____ Wt. _____ Nor. _____

Previous Abnormal Pregnancy, Pregnancy Terminations or Surgical Deliveries: (specify, giving date and reason)

Date Last Weighed During Pregnancy ___/___/___

Total Gain _____

III. DATE PATIENT DISABLED: Mo. ..... Day ..... 20 ..... **If delivered, what was the date:** Mo. ..... Day ..... 20 .....

IV. HOSPITALIZATION:

(a) Hospital _____ City _____ State—Zip _____ from ___/___/___ to ___/___/___

(b) Surgery performed _____ Date ___/___/___ Description _____

V. EXTENT OF DISABILITY: — Please review patient's job description on reverse side

a) Is patient now totally disabled for his own occupation? ..... Yes ☐ No ☐

Is patient now totally disabled for any other occupation? .... Yes ☐ No ☐

b) Date patient did or will resume work?

Regular Occupation Mo. _____ Day _____ 20 ____

Other Occupation Mo. _____ Day _____ 20 ____

c) If patient was advised to cease work more than 4 weeks pre-delivery or will not be released to resume work at 6 weeks post-delivery, please complete below:

1) Subjective Complaints:

2) Objective Findings:

3) Laboratory Testing:

Date	Test	Result

4) Treatment:

5) In view of patient's job description, what specific duties of her job is she unable to perform, i.e., lifting, environmental factors.

6) Other Activity Limitations

7) Complications, if any

	Prev. Preg.	Curr. Preg.		Prev. Preg.	Curr. Preg.
Toxemia	☐	☐	G.I. Disorders	☐	☐
Hypertension	☐	☐	Genital Tract Disorders	☐	☐
Albuminuria	☐	☐	Infectious Diseases	☐	☐
Hemorrhage	☐	☐	Psychosis	☐	☐
Rh & Blood Type Incompatibilities	☐	☐	Other (Specify)	☐	☐

OTHER MAJOR HEALTH PROBLEMS AFFECTING PREGNANCY:

Cardiovascular Disease	☐	Alcohol Addiction	☐
Renal Disease	☐	Drug Abuse/Addiction	☐
Thrombophlebitis	☐	Crippling Deformity	☐
Diabetes	☐	Other (Specify)	☐
Arthritis	☐		

Describe Conditions Indicated or Other Complications if not Listed:

VI. If patient will return to work with restriction or limitation, please describe and state how long it will be imposed.

REMARKS:

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

MUST BE FURNISHED UNDER AUTHORITY OF LAW

DATE	PHYSICIAN'S NAME (PRINT)	SIGNATURE	TELEPHONE

STREET ADDRESS	CITY OR TOWN	STATE	ZIP CODE