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 _____ HOME _____
4. GIVE DATES OF TREATMENT SINCE _____ 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**