Sheet Metal Workers' Local No. 270
Welfare Fund

1863 N. 105th East Ave. Tulsa, OK 74116 Office (918) 587-2441
Fax (918) 587-2442

DISABILITY STATEMENT OF CLAIM

Accident &/or Sickness Weekly Benefits-3rd Party Sick Pay

PLEASE PRINT OR TYPE ALL INFORMATION

Members MUST answer ALL of the following questions: Today's Date_____

Name_____ Social Security#_____

Address_____ City,State,Zip_____

Phone #_____ Email Address_____

If you were working at the time this disability occurred, what was the last day you actually worked:_____

Employer/Company you were working for:_____ Jobsite:_____

Was this sickness/injury due to an accident:_____ If so, when did the accident occur: Date__/__/__ Time_____

Where did the accident occur:_____

Were you working when the accident occurred:_____ If so, where:_____

Give a detailed description of your sickness/injury:_____

_____

What were you doing when the sickness/injury occurred:_____

_____

Were you on someone else's property when this sickness/injury occurred:_____ Owners' Name:_____

I hereby authorize the physician to release any & all information in regard to this claim. I certify that the all of the information furnished by me in support of this claim is correct and true. I understand that when I am released to return to work that (1) I am required to furnish a doctors' release to the Welfare Fund Office and that (2) I must notify the Sheet Metal Workers' Local 270 Office, before actually returning to work. My returning to work without furnishing the required doctors' release will result in the loss of all disability benefits for this & all future disabilities.

Signature_____ Date_____

Please have the attending physician complete the other side of this form & return it to the Welfare Fund Office. All Payments will be made after a two (2) week waiting period. (The 1st week of the waiting period is not payable) Claims will be processed after the form is completed & signed by the claimant and the attending physician, and the completed form is received back at the Welfare Fund Office.

All Disability Benefit Checks will be mailed to the claimant's home address only. All Disability Benefit Checks will have FICA & Medicare contributions withheld. Payments will be made on a bi-weekly basis for a maximum of twenty-six (26) weeks, or for as long as the member is disabled, whichever is less, as long as updated physicians' statements are received on a timely basis. Claimant is responsible for seeing that updated physicians' statements are sent to the Welfare Fund Office. **Ongoing physicians' statements must be received no less than every 30 days.** The gross amount of Disability Benefits paid will be reported to the Internal Revenue Service and the State of Oklahoma, as income for the reporting year.

ALL APPLICATIONS FOR CLAIMS MUST BE RECEIVED AT THE WELFARE FUND OFFICE WITHIN 30 DAYS OF ONSET OF ANY DISABILITY

To be completed by the Welfare Fund Office:

Date Form Received__/__/__

Dates of Waiting Period__/__/__ Date Payments Start__/__/__

5/4/07

ATTENDING PHYSICAINS' STATEMENT

Patient's Name:_____ D.O.B.:_____

Diagnosis:_____ Date you first treated patient for this sickness/injury:_____

Did this sickness/injury arise out of the patients' employment: _____

Nature of Surgical Procedures, if any:_____

Dates & Locations of most recent treatments, surgeries, appointments:_____

Next appointment dates:_____

Any follow-up recommendations or comments:_____

Patient is/has been continuously disabled (unable to work) from what date:_____

Patient was or will be able to return to work on (APPROXIMATE DATE):_____

Estimated date of full recovery form this disability:_____

Would you agree to notify the Welfare Fund Office, when you decide to release this patient, to return to work, by furnishing a release form?

Yes ☐ No ☐

Remarks or other information that you feel is pertinent to this sickness/injury?_____

_____

Signature (or stamp) of Physician_____ Date:_____

Mailing Address of Physician _____

_____

_____

Physicians' Office Phone# _____

(This side of form maybe photocopied & submitted for follow-up statements and changing dated information appropriately.)

When completed this form should be returned to:

SHEET METAL WORKERS' LOCAL 270
HEALTH & WELFARE FUND
1863 N. 105TH EAST AVE.
TULSA, OK 74116

Although this form may be submitted through fax, directly from the physicians' office, please always mail or bring the original to the Welfare Fund Office

5/4/07