EMPLOYEE'S STATEMENT OF CLAIM

MILWAUKEE DRIVERS HEALTH AND WELFARE TRUST FUND

WEEKLY ACCIDENT & SICKNESS BENEFITS

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TO BE COMPLETED BY THE MEMBER -*PLEASE ANSWER ALL QUESTIONS AND BE AS SPECIFIC AS POSSIBLE. IF YOU ARE UNSURE ABOUT ANY QUESTION, PLEASE CONTACT THE FUND OFFICE.*

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1. **YOUR FULL NAME (PLEASE PRINT)** _____ **PHONE #** _____
2. **COMPLETE ADDRESS** _____
   _____
3. **MALE** ☐ **FEMALE** ☐ **DATE OF BIRTH**_____ **SOCIAL SECURITY #** _____
4. **DATE YOU WERE FIRST DISABLED** _____ **LAST DAY WORKED** _____
5. **IS THIS DISABILITY RELATED TO: EMPLOYMENT? YES** ☐ **NO** ☐ **AN ACCIDENT? YES** ☐ **NO** ☐
6. **NATURE OF INJURY OR ILLNESS (DESCRIBE ILLNESS, OR HOW & WHERE THE ACCIDENT OR INJURY HAPPENED):**
   _____
   _____
   _____
7. **DATE OF ACCIDENT/INJURY** _____ **TIME** _____**A.M./P.M.**
8. **NAME OF HOSPITAL** _____ **DATES OF HOSPITALIZATION** _____
9. **DATES OF SURGERY, IF APPLICABLE** _____ **INPATIENT** ☐ **OUTPATIENT** ☐
10. **LIST ANY UNUSED, SCHEDULED VACATION WEEKS:** _____
11. **GIVE ANY ADDITIONAL INFORMATION THAT MIGHT ASSIST THE MILWAUKEE DRIVERS HEALTH AND WELFARE TRUST FUND IN THE CONSIDERATION OF THIS CLAIM (USE ADDITIONAL SHEET IF NEEDED):**
    _____
    _____

I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE INFORMATION REQUESTED WITH RESPECT TO THIS CLAIM ONLY TO THE MILWAUKEE DRIVERS HEALTH AND WELFARE TRUST FUND. I CERTIFY THAT THE INFORMATION FURNISHED IN SUPPORT OF THIS CLAIM IS TRUE AND CORRECT. I UNDERSTAND IT IS ILLEGAL AND FRAUDULENT TO FILL OUT THIS FORM WITH INFORMATION THAT I KNOW IS FALSE OR LEAVE OUT FACTS THAT I KNOW ARE IMPORTANT.

APPLICANT SIGNATURE_____ **DATE** _____

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TO BE COMPLETED BY FUND OFFICE

DATE MAILED/PICKED UP _____ **SENT BY** _____ **AMOUNT OF WEEKLY BENEFIT $**_____

IS EMPLOYEE ELIGIBLE FOR BENEFITS? YES ☐ **NO** ☐ **REASON FOR DENIAL** _____

IS MEMBER CLAIMING OR RECEIVING WORKER'S COMPENSATION BENEFITS? YES ☐ **NO** ☐

IF YES, WHAT IS THE PRESENT STATUS OF THE WORKER'S COMPENSATION CLAIM? _____

_____

EMPLOYEE NUMBER _____ **PLAN** _____ **EFFECTIVE DATE** _____

EMPLOYER_____ **CONTRACT NO** _____ **ACCIDENT**____ **SICKNESS** ____**OTHER**____

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REVERSE SIDE TO BE COMPLETED BY PHYSICIAN→

ATTENDING PHYSICIAN'S STATEMENT

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TO BE COMPLETED BY THE PHYSICIAN OR PHYSICIAN'S REPRESENTATIVE

PLEASE ANSWER ALL QUESTIONS AND BE AS SPECIFIC AS POSSIBLE.

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1. NAME OF PATIENT _____ **DATE OF BIRTH** _____

2. NATURE OF ILLNESS OR INJURY _____

3. DESCRIBE ILLNESS OR INJURY (INCLUDING ANY COMPLICATIONS/DIAGNOSIS/PROGNOSIS): _____

_____

_____

4. IS CONDITION DUE TO PREGNANCY? YES ☐ **NO** ☐ **IF YES, EXPECTED DELIVERY DATE?** _____

PLEASE INDICATE MANNER OF DELIVERY: NORMAL ☐ **CESAREAN** ☐ **MISCARRIAGE** ☐

DID PATIENT SUFFER ANY DISABLING COMPLICATIONS DUE TO THE PREGNANCY? YES ☐ **NO** ☐

DESCRIBE COMPLICATIONS: _____

_____

5. DID THIS ILLNESS OR INJURY ARISE OUT OF PATIENT'S EMPLOYMENT? YES ☐ **NO** ☐

IF YES, EXPLAIN _____

_____

_____

6. DATES OF TREATMENT: OFFICE VISITS: _____

INPATIENT HOSPITAL: _____

OUTPATIENT: _____

SURGERY: _____

7. PATIENT HAS BEEN CONTINUOUSLY DISABLED (UNABLE TO WORK): FROM _____ **TO** _____
DATE **DATE**

8. PATIENT WAS OR WILL BE ABLE TO RETURN TO WORK *WITHOUT RESTRICTIONS* (APPROX): _____
DATE

9. PLEASE LIST ANY WORK RESTRICTIONS AND THE DATES: FROM _____ **TO** _____
DATE **DATE**

_____

_____

10. NEXT APPOINTMENT IS SCHEDULED FOR (DATE): _____

11. NAME OF ATTENDING PHYSICIAN: _____

CLINIC (IF APPLICABLE): _____

ADDRESS: _____

_____

TELEPHONE NO: _____ **FAX NO:** _____

PHYSICIAN'S SIGNATURE _____ **DATE** _____

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PLEASE ATTACH ANY INFORMATION YOU FEEL IS PERTINENT TO THIS CLAIM. COMPLETION OF THIS FORM IN ITS ENTIRETY WILL MEAN TIMELY PROCESSING OF THIS CLAIM. IF YOU HAVE QUESTIONS, CONTACT THE FUND OFFICE AT (414) 258-2336. RETURN THE COMPLETED FORM TO FAX # (414) 258-9419 BETWEEN BUSINESS HOURS M-F 8:00AM TO 4:30PM OR MAIL TO:

MILWAUKEE DRIVERS HEALTH AND WELFARE TRUST FUND

10020 WEST GREENFIELD AVENUE

MILWAUKEE, WI 53214

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