Twin City Iron Workers Health and Welfare Fund

Group 5WM00140

DISABILITY CLAIM FORM (PREGNANCY)

NO BENEFITS CAN BE PAID UNLESS THIS FORM IS COMPLETED IN ITS ENTIRETY

Maximum Number of Weeks Payable per Period of Total Disability: 26

This form must be completed on or about: ______________

Return completed form to:
Twin City Iron Workers Health and Welfare Fund
3001 Metro Drive • Suite 500
Bloomington, MN 55425
(952)854-0795 • (800)535-6373 • Fax: (952)851-3521

MEMBER COMPLETES THIS SECTION

Name of Member		Home Phone	
Date of Birth	Social Security Number		Last Date Worked
Home Address	City	State	Zip Code

DOCTOR COMPLETES THIS SECTION

To collect disability benefits during your pregnancy, your doctor must complete the below questions and sign & date this form.

Date patient first consulted you for this condition	Is the patient still under your care for this condition? ☐ Yes ☐ No
Frequency of Visits: ☐ Weekly ☐ Monthly ☐ Other:	
Patient was continuously totally disabled (unable to work her regular occupation) due to pregnancy: From Thru	Date patient should be able to return to work
Print Doctor's Name	Doctor's Signature

Degree	Date	Telephone	
Street Address	City	State	Zip Code

I hereby make claim for benefits and certify that the above statements are true and correct to the best of my knowledge and belief. I authorize the above named institution or physician to release information concerning my enrollment, related records and medical records to the Twin City Iron Workers Health and Welfare Fund.

Insured Member's Signature	Date