

## Twin City Iron Workers Welfare Fund

### DISABILITY CLAIM - SUPPLEMENTARY

This form MUST be completed on or about: \_\_\_\_\_

Policy Number: **CP14**

#### **PART A: TO BE COMPLETED BY PATIENT (INSURED)**

<p><b>1. Personal Information</b></p> <p>Your Name: _____</p> <p>Social Security Number: _____</p> <p>Date of Birth: _____</p> <p>Address: _____</p> <p>_____</p>	<p><b>2. Authorization to release information:</b></p> <p>I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment. I also make claim for benefits and certify that the statements under Part A are true and complete to the best of my knowledge.</p> <p>_____ Signature of Insured</p> <p>_____ Date</p>
<p><b>3. State last day worked because of disability:</b></p> <p>_____/_____/_____ month      day      year</p>	<p><b>4. On what date were or will you be able to perform full-time work:</b></p> <p>_____/_____/_____ month      day      year</p>
<p><b>5. If injured, how and where did the accident occur?</b></p>	<p><b>6. Did injury occur in the course of employment?</b></p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>7. Have you or do you intend to file this claim under Workmen's Compensation?</b></p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b>8. Are you now engaged in the duties of any occupation or endeavor for wages, profits or compensation?</b></p> <p style="text-align: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

#### **PART B: ATTENDING PHYSICIAN'S STATEMENT**

<p><b>9. Diagnosis and concurrent conditions:</b></p>	
<p><b>10. Frequency of visits:</b></p> <p><input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other: _____</p>	<p><b>11. Is patient totally disabled from any occupation?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Date patient became totally disabled: ____/____/____ month      day      year</p>
<p><b>12. Is patient totally disabled from his/her regular occupation?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Date patient became totally disabled: ____/____/____ month      day      year</p>	<p><b>13. On what date will the patient be able to resume normal activities and return to work?</b></p> <p>_____/_____/_____ month      day      year</p>
<p><b>14. Attending Physician's Information:</b></p> <p>Physician's Name: _____</p> <p>Physician's Signature: _____</p> <p>Degree: _____ Date: _____</p> <p>Address: _____</p> <p>_____</p>	<p><b>15. Remarks:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

**Return completed forms to:**

Wilson-McShane Corporation, Attn: Claims Department, 3001 Metro Drive – Suite 500, Bloomington, MN 55425  
 Phone: 952-854-0795, Toll Free: 800-535-6373, Fax: 952-851-3521