DISTRICT COUNCIL 37 HEALTH & SECURITY PLAN

125 BARCLAY STREET, NEW YORK, N.Y. 10007

HS:DIS 013

Please Type or Print

SHORT-TERM DISABILITY BENEFIT CLAIM

Phone: (212) 815-1234

TO BE FULLY COMPLETED BY EMPLOYEE AND FILED WITHIN 15 DAYS FROM THE DAY YOU BECOME DISABLED REGARDLESS OF SICK, VACATION OR ANNUAL TIME.

EMPLOYEE INFORMATION

Name _____ Soc. Sec. No. _____

Home Address _____
No. & Street City State Zip

Date of Birth _____ Male ☐ Female ☐ Home Phone _____

JOB INFORMATION

Name of your work place _____ Date of Employment _____

Work Address _____ Timekeeper

Department _____ Personnel Phone No. _____ Payroll

Job Title _____ If school worker, District Office No. _____

Annual Salary _____ Hours worked per day _____

How many sick days did you have on the date you become disabled? _____

ILLNESS INFORMATION

When did you become totally disabled so that you could not work? Date: _____

What date did you first see a doctor? _____ Name of doctor _____

Describe your illness _____

Have you returned to work yet? Yes ☐ No ☐ If yes, what date? _____

Have you ever received disability payments for the same illness? Yes ☐ No ☐ If yes, what year? _____

IF CONFINED IN HOSPITAL

Name of Hospital _____

Address of Hospital _____

Date Admitted _____ ☐ AM ☐ PM Date Discharged _____

IF DISABILITY IS DUE TO ACCIDENT

A. Date of accident _____ ☐ AM ☐ PM B. How did it happen? _____

C. Did it happen at work? Yes ☐ No ☐ D. Did you file for Workers' Compensation? Yes ☐ No ☐

E. Is there a lawsuit? Yes ☐ No ☐

F. If yes, give attorney's name _____

Address _____ Phone No. _____

SIGN HERE

The above statements are true and complete to the best of my knowledge and belief and I hereby authorize any hospital or physician who has treated me to furnish any and all medical information to District Council 37 Health and Security Plan.

Signature _____ Date _____

(SIGNATURE ONLY—DO NOT PRINT)

IF YOU ARE PLANNING TO GO OUT OF THE NEW YORK AREA AFTER YOU HAVE APPLIED FOR DISABILITY BENEFITS, YOU MUST CONTACT THE HEALTH & SECURITY PLAN OFFICE OR YOUR CLAIM WILL BE DECLARED INELIGIBLE.

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ATTENDING PHYSICIAN'S STATEMENT

Patient_____ Claim No._____ Age_____ Sex_____

DIAGNOSTIC CATEGORY

A. Medical Conditions/Diagnosis

***(IMPORTANT:* THIS CLAIM CANNOT BE PROCESSED WITHOUT THE APPROPRIATE ICD CODES.)**

	ICD CODE	DESCRIPTION
Primary Diagnosis	_____.____	_____
Secondary Diagnosis	_____.____	_____
	_____.____	_____

Is patient's disability related to Substance Abuse YES ☐ NO ☐ and/or Alcoholism YES ☐ NO ☐

Is patient's disability related to an accident? YES ☐ NO ☐

Is patient's disability a result of an injury arising out of and in the course of employment or an occupational disease? YES ☐ NO ☐

TREATMENT INFORMATION

B. Specific Dates of Treatment for this Illness: _____; _____; _____; _____; _____

If hospitalized for this disability: Date Admitted_____ Date Discharged_____

Name of Hospital:_____ Address:_____

If surgery was performed, give the date(s): _____

Type of Surgery: *(with CPT code)*_____

If pregnancy, list date, or expected Date of Delivery: _____

Type of delivery: Normal ☐ C-Section ☐

Are there other disabling conditions accompanying this pregnancy? YES ☐ NO ☐

If yes, please list::_____

C. Therapy

Is patient receiving Chemotherapy, Radiation or on Dialysis? YES ☐ NO ☐

If yes, give dates: _____; _____; _____; _____; _____; _____; _____; _____

Is patient receiving Physical Therapy? YES ☐ NO ☐

If yes, give dates: _____; _____; _____; _____; _____; _____; _____; _____

Is patient in a program for Substance Abuse? YES ☐ NO ☐

Name of Program_____ Telephone Number_____

Dates in attendance: _____; _____; _____; _____; _____; _____; _____

D. Anticipated Duration For This Disability

(Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)

Patient's disability is expected to extend from_____ through_____

SIGN HERE

_____ Physician's Signature	_____ Name (Print)	_____ Degree Specification
_____ Licensed in the State of	_____ License Number	
_____ Address	_____ Phone	_____ Date

REV:5/98