PLUMBERS, PIPEFITTERS & MES LOCAL UNION No. 392 FRINGE BENEFIT FUNDS
1228 Central Parkway, Room 100 · Cincinnati, OH 45202
Phone: 513-241-0444 · Fax: 513-241-1130 · Email: mcefaratti@local392fringefunds.com

DISABILITY FORM

EMPLOYEE'S INFORMATION & STATEMENT

Name _____ D.O.B. _____ SS# (last four) _____

Phone _____ Email _____

Employer _____ Last day worked _____

IF CLAIM IS DUE TO SICKNESS, PLEASE DESCRIBE:

_____

_____

IF CLAIM IS DUE TO AN ACCIDENT, PLEASE ANSWER THE FOLLOWING QUESTIONS:

Date of accident: _____ Time of accident: _____

Where did the accident happen? ☐ Work ☐ Home ☐ Other _____

How did the accident occur?_____

_____

_____

Has there been or will there be a claim filed for this disability with the workers compensation carrier? ☐ Yes ☐ No

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment.

Signed (patient): _____ Date: _____

THIS FORM IS FOR WEEKLY A&S BENEFITS ONLY. DO NOT USE IT TO FILE YOUR MEDICAL BILLS

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DISABILITY FORM

ATTENDING PHYSICIAN'S STATEMENT & INFORMATION

Patient: Date of birth:

DATE OF FIRST TREATMENT FOR THIS DISABILITY:	DATES OF DISABILITY (dates need to be specific): FROM THRU	ESTIMATED RETURN TO WORK DATE:
DIAGNOSIS/ICD9 (including complications):		
WAS SURGERY PERORMED? ☐ YES ☐ NO	DATE PERFORMED:	
TYPE OF SURGERY/CPT CODE:		
IS PATIENT'S CONDITION DUE TO EMPLOYMENT? ☐ NO ☐ YES, PLEASE EXPLAIN:		
IS PATIENT TOTALLY DISABLED? ☐ YES ☐ NO - PLEASE EXPLAIN:		

THIS FORM MUST BE SIGNED OFF BY A DOCTOR OF MEDICINE OR A DOCTOR OF OSTEOPATHIC MEDICINE

PHYSICIAN'S NAME AND DEGREE (print)		
ADDRESS		
PHONE	FAX	FED I.D. #
SIGNATURE		DATE