

DISABILITY CLAIM FORM

Toledo Electrical Welfare Fund

P.O. Box 60408
Rossford, Ohio 43460

Telephone: 419/666-4450
Fax: 419/666-5410

PARTICIPANT INFORMATION

Name of Insured _____ Last 4 Digits of Social Security Number _____

Street Address _____ Telephone Number with area code _____

City _____ State _____ Zip Code _____ Date of Birth _____

Marital Status Married Divorced Sex Male
Single Legal Separation Female
Widowed

I realize that failure to disclose other insurance coverage information or to falsify information to the TEWF is considered a fraudulent act against the Fund. A fraudulent act may result in denial of eligibility under the benefit plans.

Signature _____ Date _____

Disability Income Benefit - Participant Only

Were you employed on the date of disability began? Yes No Did disability begin while on the job? Yes No

When did disability begin? _____ Name of Employer at time of disability: _____

Was this an accident or illness? _____ If Accident, describe what happened and where? _____

Have you received any income from Unemployment Compensation since the date the disability began? Yes No

Have you received any income from Workers' Compensation since the date the disability began? Yes No

Attending Physician's Statement

Diagnosis and concurrent conditions - Please use ICD-9 (International Classification of Disease) Diagnosis Code number as well as written description: _____

Is condition due to injury or sickness arising out of patient's employment? Yes No

Pregnancy? Yes No If yes, approximate date pregnancy commenced: _____

Date patient first consulted you for this condition: _____

Has patient ever had same or similar condition? Yes No

If yes, please describe and list dates: _____

Is Patient still under your care for this condition? Yes No

Patient was continuously and totally disabled (unable to work) from: _____ To: _____

Patient was partially disabled from: _____ To: _____

If still disabled, date patient can return to work: _____

Physician's Name _____ Taxpayer ID number or Social Security Number _____ Telephone Number with area code _____

Address _____ City _____ State _____ Zip Code _____

Physician's Signature _____ Date _____