IMPORTANT
Notice of claim must be filed within 7 days of commencement of disability or within 7 days following discharge from the hospital.

UFCW LOCAL 1776 AND PARTICIPATING EMPLOYERS HEALTH AND WELFARE FUND

3031B Walton Road • Plymouth Meeting, PA 19462
(610) 941-9400

WEEKLY GROUP ACCIDENT & SICKNESS DISABILITY INSURANCE CLAIM FORM

FOR USE BY MEMBERS OF LOCAL 1776

IMPORTANT
Make sure your store manager has sent your Health and Accident report form to the Fund Office.

THE EMPLOYEE MUST COMPLETE AND SIGN

(Please Print)

A. Full time ☐ Part time ☐

B. Employee's Name _____ Social Security No. _____

Address _____ Home Phone No. _____

City _____ State _____ Zip Code _____

Company _____ Store No. _____ Local Union _____ Date of Birth _____

C. Description of Accident: (Please provide details of your accident.) (If this claim involves an accident answer 1, 2, 3, 4, otherwise skip to D)

1. Date of Accident: _____
2. How accident happened: _____
3. Where did this accident occur (location): _____
4. Do you feel that your accident was caused by the fault of any one other than you or your employer? If so, state who is responsible and why you feel that they are responsible: _____

D. Date your Sickness or Pregnancy began: _____

E. Is this Accident or Sickness Due to your Employment? Yes ☐ No ☐

F. Have you filed a claim with your Store Manager for Workmen's Compensation? Yes ☐ No ☐

G. Name and Address of Hospital: _____

1. Date Admitted to Hospital: _____
2. Date of Discharge: _____

I hereby authorize any physician, hospital, pharmacy, insurance company, employer or organization to release any information regarding the medical history, treatment, disability, or benefits payable for this claim, to the UFCW Local 1776 and Participating Employers Health and Welfare Fund. A photostat of this authorization shall be as valid as the original.

SIGN HERE

_____
Employee's Signature *Date*

RETURN THIS FORM TO THE FUND OFFICE

You and your physician must complete this form in its entirety and return immediately to the Fund Office.

Revised 10/01

To Be Completed and Signed ONLY by the Physician

ACCIDENT AND SICKNESS DISABILITY CLAIM **APS**

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name	Date of Birth

Diagnosis and Concurrent Conditions Use ICD-9 Diagnosis Code
(If fracture or dislocation, describe nature and location)

Is Condition Due to Injury or Sickness Arising Out of Patient's Employment? Yes ☐ No ☐

Pregnancy? Yes ☐ No ☐

If Yes, Estimated Due Date (Date)

Report of Services (or attach itemized bill) (If previous form submitted to this carrier, you need show only dates and services since last report)

Date of Services	Place of Service†	Description of Surgical or Medical Services Rendered	Procedure Code — If Used (If code other than CPT** used, give name)

†O — Doctor's Office
H — Patient's Home
*ICDA — International Classification of Diseases
**CPT — Current Procedural Terminology (current edition)
IH — Inpatient Hospital
OH — Outpatient Hospital
NH — Nursing Home
OL — Other Locations
SPU — Short Procedure Unit

Date Symptoms First Appeared or Accident Happened.	Date Patient First Consulted You for This Condition.
Patient Ever Had Same or Similar Conditions? Yes ☐ No ☐ If "Yes" when and describe.	Patient Still Under Your Care for This Condition? Yes ☐ No ☐
Patient was Continuously Totally Disabled (unable to work). From Thru	If Still Disabled, Date Patient Should Be Able to Return to Work.
Patient was House Confined. From Thru	Does Patient Have Other Health Coverage? Yes ☐ No ☐ If "Yes" Please identify

In accordance with provisions of Internal Revenue Service Ruling 69-595, we are required to obtain your Social Security Number (Employer Identification Number in the case of associations, corporations, and other providers who are not individuals) when issuing benefits directly to you. Would you please enter the number applicable below and return this form to the address shown above. Thank you for your cooperation.

S.S. No. _____ Employer I.D. No. _____ Physician's Name (Print) _____

Date | Signature (Attending Physician) | Degree | Telephone

Street Address | City or Town | State | Zip | Fax #

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