

**IMPORTANT**

Notice of claim must be filed within 40 days of commencement of disability or within 40 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.**



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

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 #