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

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

WEEKLY GROUP ACCIDENT AND SICKNESS DISABILITY CLAIM FORM

For Use by Members of Local 1776. THE EMPLOYEE MUST COMPLETE, SIGN, AND RETURN TO THE FUND

UFCW Local 1776 and Participating Employers Health and Welfare Fund
3031 B Walton Road
Plymouth Meeting, PA 19462
Phone: (610) 941-9400 Fax: (610) 941-9602

INFORMATION RECEIVED

Voice Mail Box Caller Mail

Date of Call:	**Time of Call:**	
Caller Name:	**Relationship:**	**Phone Number:**

EMPLOYEE INFORMATION

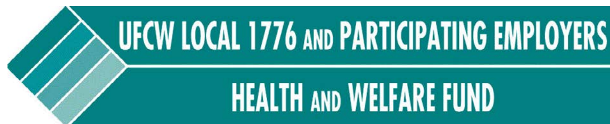
Full Time Part Time

Full Name:		
Home Address:	**City:**	**State:** **Zip:**
Date of Birth:_____/_____/_______	**Social Security No. XXX-XX-__ __ __ __**	
Home Phone No.	**Mobile Phone No.**	**Fax No.**
Email Address:		
Job Title:		**Store No.**
Employer Name:	**Contact Person:**	**Phone No.**
Description of Job Duties:		

DISABILITY INFORMATION

DUE TO: Accident Illness Pregnancy

Is this Disability related to a prior disability claim? Yes No		
If yes, provide details of prior Disability:		
PREGNANCY INFORMATION		
Due Date:	**If pregnancy complications, date began:**	
ACCIDENT/SICKNESS INFORMATION		
Date of Accident/Sickness:		
Description of Accident/Sickness, including how and where it occurred:		
IF ACCIDENT:	**Motor Vehicle Accident? Yes No**	**Claim No.**
	Work Related Accident? Yes No	
Do you believe your Accident/Sickness is caused by or primarily related to your job? Yes No		
Please explain:		
Have you filed a Workers Compensation claim? Yes No	**Claim No.**	
Do you feel that any other parties are responsible for your accident? Yes No		
Please explain:		
Attorney Name:	**Phone No.**	



WEEKLY GROUP ACCIDENT AND SICKNESS DISABILITY CLAIM FORM

For Use by Members of Local 1776. THE EMPLOYEE MUST COMPLETE, SIGN, AND RETURN TO THE FUND

DISABILITY INFORMATION (CONTINUED)

Have you worked for wages or profits since the date of your disability? Yes No			
Are you receiving wage-loss benefits from another source? Yes No			
If Yes, please provide source:			
DOCTOR/HOSPITAL INFORMATION			
Treating Physician Name:			
Address:	**City:**	**State:**	**Zip:**
Phone No.	**Fax No.**		
Date first seen by physician:	**Additional appointment dates:**		
Next scheduled appointment date:			
Did your treating physician refer you to another doctor? Yes No			
If Yes, name, address and reason for referral:			
Referral Physician Name:			
Address:	**City:**	**State:**	**Zip:**
Reason for Referral:			
If Hospitalized:			
Hospital Name:			
Address:	**City:**	**State:**	**Zip:**
Date Admitted:	**Date Discharged:**		
Please provide any additional information/comments related to this disability claim:			

PARTICIPANT: PLEASE READ AND SIGN BELOW:

Any person who knowingly, and with intent to defraud the Fund and/or other parties, files a statement or claim containing any materially false information, or conceals information, for the purpose of misleading the Fund and/or other parties concerning any fact material to this claim, commits a fraudulent insurance act which is a crime.

I have read the above and verify that the information contained on this report is true and accurate.

Participant Certification: Signature

Date

AUTHORIZATION

I hereby authorize any physician, hospital, pharmacy, employer, organization, or insurance company, including any workers compensation carrier or motor vehicle insurance carrier under which I may receive any payment in connection with the injuries for which I am claiming disability benefits from the UFCW Local 1776 and Participating Employers Health & Welfare Fund (hereafter, "the Fund"), to release to the Fund, any and all information with respect to any injury or illness, including mental illness, drug/alcohol abuse, HIV-related, AIDS, or AIDS-related information to the extent permitted by law, medical history, consultations, prescriptions, treatments, or benefits and copies of all applicable records that may be requested for the purpose of processing a claim for benefits. The Fund is also authorized to disclose such information to any doctor or service, including case management, for the purpose of evaluating a claim for benefits.

Signature

Date

RETURN THIS FORM TO THE FUND OFFICE