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

UFCW HEALTH AND WELFARE FUND OF NORTHEASTERN PENNSYLVANIA

IMPORTANT
Make sure your Employer has sent your Health and Accident report form to the Fund office.

DISABILITY CLAIM FORM – EMPLOYEE FORM

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

UFCW Health and Welfare Fund of Northeastern Pennsylvania
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.	Cell Phone No.	Fax No.	
Email Address:			
Job Title:			
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.		

UFCW Health and Welfare Fund of Northeastern Pennsylvania

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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 Health & Welfare Fund of NEPA (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