INTERNATIONAL UNION OF OPERATING ENGINEERS
LOCALS 181, 320 & TVA
HEALTH & WELFARE TRUST FUND

Health Insurance Disability Claim Form

Applicant Information

Member's Name: _____ Date of Birth: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Social Security # : _____ Email: _____

AUTHORIZATION TO RELEASE INFORMATION: *I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment.*

Member's Signature: _____ Date: _____

Attending Physician's Statement

TO BE COMPLETED BY ATTENDING PHYSICIAN: *The following information is needed to document the patient's inability to work. The patient is responsible for obtaining a complete form without expense to the Health & Welfare Fund.*

Diagnosis: _____ ICDA Classification: _____

Patient was continuously totally disabled (unable to work): From: _____ Thru: _____

PHYSICIAN INFORMATION: *Please type or print.*

Name of Physician: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone No.: _____

Physician's Signature: _____ Date: _____