SHEET METAL WORKERS' LOCAL 292
FRINGE BENEFIT FUNDS
P.O. Box 189
Troy, MI 48099-0189
(248) 641-4992 (888) 646-6565

Date_____

_____

_____

_____

Application for Disability Benefits Form

Attached you will find the above form that was recently requested from our office. Incomplete applications submitted to our office will be returned for completion. To avoid any delays in the processing of your benefits please make sure to follow the guidelines outlined below.

- ☐ **The employee must complete the top portion of both the front and reverse sides of the form.**
- ☐ **Any accidental injuries must be described in detail in the box provided on the front of the form.**
- ☐ **The lower portion of the front of the form must be completed in full by the employee's employer.**
- ☐ **Your attending Physician must complete <u>PART B</u> the reverse side of the form including the dates that you are totally disabled.**

Once the completed application is received in our office your claim will receive prompt attention. Please feel free to contact our office should you have any questions.

Thank You.

Claims Department

SHEET METAL WORKERS' LOCAL UNION NO. 292
FRINGE BENEFIT FUNDS

P.O. Box 189 / Troy, MI 48099-0189 / 1-248-641-4992

NOTE: YOUR APPLICATION FOR BENEFITS WILL BE DELAYED UNLESS ALL QUESTIONS ARE FULLY COMPLETED.

TO BE COMPLETED BY THE EMPLOYEE

_____
EMPLOYEE'S NAME (PLEASE PRINT)

_____
NO. AND STREET

_____
CITY STATE ZIP

_____
DATE OF BIRTH SOCIAL SECURITY NO.

_____
TELEPHONE NO.

NAME OF LAST EMPLOYER_____

DATE LAST EMPLOYED_____

ARE YOU, YOUR SPOUSE OR CHILD COVERED UNDER ANY OTHER HOSPITAL, SURGICAL, MEDICAL BENEFIT PLAN?
☐ NO ☐ YES

IF YES, PLEASE COMPLETE
☐ GROUP PLAN ☐ INDIVIDUAL POLICY ☐ SCHOOL PLAN

_____
NAME OF OTHER PLAN

_____
OTHER POLICY NUMBER

IF CLAIM IS FOR DEPENDENT

NAME OF DEPENDENT_____

DATE OF BIRTH _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED
☐ WIDOWED ☐ SEPARATED ☐ DIVORCED

_____EMPLOYED? ☐ YES ☐ NO
SPOUSE'S NAME

_____
NAME OF SPOUSE'S PRESENT OR MOST RECENT EMPLOYER

_____
ADDRESS OF SPOUSE'S EMPLOYER

_____
NAME OF SPOUSE'S INSURANCE CARRIER - POLICY NO.

I HEREBY APPLY FOR BENEFITS FOR: ☐ SELF ☐ SPOUSE ☐ UNMARRIED CHILD

IS DEPENDENT A STUDENT?
☐ YES ☐ NO ☐ FULL TIME ☐ PART TIME

IS DEPENDENT CARRIED AS AN INCOME TAX EXEMPTION?
☐ YES ☐ NO

COMPLETE ONLY IF CLAIM CAUSED BY INJURY	DATE OF INJURY, HOUR (AM/PM) Where did the accident happen? _____ HOW DID IT HAPPEN? _____
COMPLETE ONLY IF CLAIM CAUSED BY ILLNESS	HAS TREATMENT EVER BEEN RENDERED FOR THIS CONDITION BEFORE? ☐ YES ☐ NO WHEN WAS THE PHYSICIAN FIRST CONSULTED? (DATE)_____
COMPLETE IF CLAIM INCLUDES DISABILITY BENEFITS FOR EMPLOYEES	FIRST DATE YOU WERE UNABLE TO WORK? _____ DATE YOU RETURNED TO WORK?_____ IS DISABILITY A RESULT OF EMPLOYMENT? ☐ YES ☐ NO

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I HEREBY AUTHORIZE ALL DOCTORS, HOSPITALS OR OTHER INSTITUTIONS RENDERING CARE AND TREATMENT TO FURNISH THE SHEET METAL WORKERS' LOCAL UNION NO. 292 – FRINGE BENEFIT FUNDS WITH FULL INFORMATION REGARDING TREATMENT RENDERED (INCLUDING COPIES OF THEIR RECORDS). I ALSO AUTHORIZE ANY UNION, TRUST FUND, EMPLOYER OR INSURANCE CARRIER TO FURNISH THE SHEET METAL WORKERS' LOCAL UNION NO. 292 – FRINGE BENEFIT FUNDS WITH INFORMATION REGARDING BENEFITS TO WHICH I OR ANY OF MY DEPENDENTS MAY BE ENTITLED.

EMPLOYEE'S SIGNATURE _____DATE_____

PLEASE BE SURE TO ATTACH ITEMIZED BILLS

TO BE COMPLETED BY EMPLOYER FOR EMPLOYEE WEEKLY DISABILITY BENEFITS ONLY -

(1) OCCUPATION		DATE LAST WORKED	DATE RETURNED TO WORKED DID DISABILITY OCCUR DUE TO OCCUPATIONAL CAUSES ☐ YES ☐ NO
(2) HAS EMPLOYMENT TERMINATED? ☐ YES ☐ NO	WHEN	FOR WHAT REASON	
(3) DOES THE EMPLOYEE HAVE OTHER INSURANCE COVERAGE FOR THIS CLAIM? ☐ YES ☐ NO IF YES, EXPLAIN			
EMPLOYER _____		SIGNED BY _____	
DATE _____		TITLE_____	

ATTENDING PHYSICIAN'S STATEMENT ON REVERSE SIDE

HEALTH BENEFIT CLAIM - GROUP

PART A — TO BE COMPLETED BY PATIENT (EMPLOYEE)

PATIENT'S NAME AND ADDRESS | DATE OF BIRTH

Sheet Metal Workers' Local Union No. 292
Fringe Benefit Funds
P.O. Box 189 / Troy, MI 48099-0189

EMPLOYEE'S SOCIAL SECURITY NO.

CLAIMANT'S ASSIGNMENT (Read before signing):
I hereby authorize Sheet Metal Workers' Local Union No. 292–Fringe Benefit Funds to pay directly to the above named physician the Medical or Surgical Expense Benefits to which I am entitled under the terms of the Plan to the extent of his interest as established herewith.

SIGNATURE OF CLAIMANT _____ DATE _____

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

PATIENT'S SIGNATURE (PARENT'S SIGNATURE IF PATIENT IS A MINOR

DATE

PART B — ATTENDING PHYSICIAN'S STATEMENT

1. DIAGNOSIS AND CONCURRENT CONDITIONS
(If diagnosis code other than ICDA* used, give name):

2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? ☐ YES ☐ NO | PREGNANCY? ☐ YES ☐ NO | IF YES, APPROXIMATE DATE PREGNANCY COMMENCED DATE

3. REPORT OF SERVICES (Or attach itemized bill) (If previous form submitted, you need show only dates and services since last report).

Date of Services	Place of Services	Description of Surgical or Medical Services Rendered	Procedure Code - if used (If code other than CPT** used, give name)	Charges

IO - DOCTOR'S OFFICE IH - INPATPIENT HOSPITAL NH - NURSING HOME
H - PATIENT'S HOME OH - OUTPATIENT HOSPITAL OL - OTHER LOCATION
*ICDA - INTERNATIONAL CLASSIFICATION OF DISEASES
**CPT - CURRENT PROCEDURAL TERMINOLOGY (CURRENT EDITION)

TOTAL CHARGES $_____
AMOUNT PAID $_____
BALANCE DUE $_____

4. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED

5. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION

6. PATIENT EVER HAD SAME OR SIMILAR CONDITION? ☐ YES ☐ NO If yes, when and describe

7. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO

8. PATIENT EVER CONTINUOUSLY TOTALLY DISABLED (Unable to work)
FROM THRU

9. PATIENT WAS PARTIALLY DISABLED
FROM THRU

10. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK

11. PATIENT WAS HOUSE CONFINED
FROM THRU

12. DOES PATIENT HAVE OTHER HEALTH COVERAGE? ☐ YES ☐ NO If yes, please identify

Must be furnished under authority of law.
Individual practitioner's - S.S. No.
All others - I.D. No.

13. I DO NOT ACCEPT ASSIGNMENT ☐

DATE | PHYSICIAN'S NAME (print) | SIGNATURE | DEGREE | TELEPHONE

STREET ADDRESS | CITY OR TOWN | STATE OR PROVINCE | ZIP CODE

MEMORANDUM REGARDING DISPOSITION OF THIS FORM ON REVERSE SIDE

APPROVED BY COUNCIL ON MEDICAL SERVICE. AMA 10-62