Heat and Frost Insulators Local 34 Health & Welfare Trust
3001 Metro Drive, Suite 500 · Bloomington, MN 55425 · P: 952·851·5948 · F: 952·854·1632

DISABILITY CLAIM - SUPPLEMENTARY

This form MUST be completed on or about: _____

PART A: *TO BE COMPLETED BY PATIENT (INSURED)*

1. Personal Information

Your Name: _____

Social Security Number: _____

Date of Birth:_____

Address:_____

_____

2. Authorization to release information:

I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment. I also make claim for benefits and certify that the statements under Part A are true and complete to the best of my knowledge.

_____ _____
Signature of Insured Date

3. State last day worked because of disability:

_____ / _____ / _____
month day year

4. On what date were or will you be able to perform full-time work:

_____ / _____ / _____
month day year

5. If injured, how and where did the accident occur?

6. Did injury occur in the course of employment?

❑ Yes ❑ No

7. Have you or do you intend to file this claim under Workmen's Compensation?

❑ Yes ❑ No

8. Are you now engaged in the duties of any occupation or endeavor for wages, profits or compensation?

❑ Yes ❑ No

PART B: *ATTENDING PHYSICIAN'S STATEMENT*

9. Diagnosis and concurrent conditions:

10. Frequency of visits:

❑ Weekly ❑ Monthly ❑ Other:_____

11. Is patient totally disabled from any occupation?

❑ Yes ❑ No

Date patient became totally disabled: _____ /_____ /_____
month day year

12. Is patient totally disabled from his/her regular occupation?

❑ Yes ❑ No

Date patient became totally disabled: _____ /_____ /_____
month day year

13. On what date will the patient be able to resume normal activities and return to work?

_____ / _____ / _____
month day year

14. Attending Physician's Information:

Physician's Name: _____

Physician's Signature:_____

Degree:_____ Date:_____

Address:_____

_____

15. Remarks:

_____

_____

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