HEALTH AND BENEFIT TRUST FUND OF THE ENGINEERS UNION LOCAL 94-94A

337 West 44th Street, New York, NY 10036 - Tel. (212) 541-9880

SCHOOL DIVISION CLAIM FORM FOR WEEKLY LOSS OF TIME

TO BE COMPLETED BY MEMBER

PART (A): MEMBER INFORMATION

1. MEMBER'S SOCIAL SECURITY NUMBER

2. MEMBER'S NAME AND ADDRESS

Last First

No. and Street Apt. No.

City State Zip Code

( )
Telephone No.

3. MEMBER'S EMPLOYER & JOB LOCATION WORK PHONE #

4. DATE OF BIRTH
MONTH DAY YEAR

SEX
☐ M ☐ F

5. CHECK ONE BOX ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

MEMBER'S SIGNATURE

SIGNATURE Dated

When this claim has been processed and you are still disabled, an updated form completed by you and your doctor must be submitted.

6 MY DISABILITY IS:

A. I BECAME DISABLED ON: _____

B. MY DISABILITY IS DUE TO (DESCRIBE ILLNESS OR INJURY) _____

C. I HAVE SINCE WORKED FOR WAGES OR PROFIT. ☐ YES ☐ NO

IF YES, GIVE DATES: _____

7. FOR THE PERIOD COVERED BY THIS CLAIM, I HAVE RECEIVED OR AM CLAIMING:

A. DAMAGES FOR PERSONAL INJURY ☐ YES ☐ NO

B. BENEFITS UNDER WORKER'S COMPENSATION ☐ YES ☐ NO

C. UNEMPLOYMENT INSURANCE ☐ YES ☐ NO

8a. WAS INJURY OR CONDITION RELATED TO:

A. PATIENT'S EMPLOYMENT ☐ YES ☐ NO B. ACCIDENT ☐ AUTO ☐ OTHER

8b. IF ACCIDENT, GIVE DATE _____ MONTH/DAY/YEAR

8c. IS OR WILL LEGAL ACTION BE TAKEN? ☐ YES ☐ NO

8d. LAWYER'S NAME AND ADDRESS, IF ANY: _____

PLEASE NOTE: THIS BENEFIT IS SUPPLEMENTAL TO NEW YORK STATE DISABILITY. **(If injury or condition is related to employment, you are not entitled to this benefit.)**
PLEASE CONTACT YOUR EMPLOYER TO FILE FOR NEW YORK STATE DISABILITY.

TO BE COMPLETED BY PHYSICIAN OR SUPPLIER

PART (B): PHYSICIAN OR SUPPLIER INFORMATION — Please complete all items

1. Date of First Treatment for Condition

2. Is this an initial consultation? ☐ Yes ☐ No

3. Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No Accident? ☐ Yes ☐ No

4. For service related to hospitalization, give hospitalization dates:
Admitted _____ Discharged _____

4 a. Surgery Indicated ☐ Yes ☐ No
Type _____ Date _____

5. Diagnosis or nature of illness or injury (if diagnosis code other than ICD9*, give name)

	ICD9 CODE
1. Primary	
2. Secondary	

6. Please enter dates for the following:

	MONTH	DAY	YEAR
A. DATE OF YOUR FIRST TREATMENT FOR THIS DISABILITY:			
B. DATE OF YOUR MOST RECENT TREATMENT FOR THIS DISABILITY:			
C. DATE CLAIMANT WAS UNABLE TO WORK DUE TO THIS DISABILITY:			
D. DATE CLAIMANT WILL BE ABLE TO PERFORM USUAL WORK: ***(EVEN IF CONSIDERABLE QUESTION EXISTS, ESTIMATE DATE. AVOID USE OF TERMS SUCH AS "UNKNOWN" OR "UNDETERMINED".)***			

OFFICE USE ONLY

7. Physician's name (print) _____ 8. Board Certified Specialty _____

9. Physician's signature _____ 10. Date _____

11. Street address _____ City _____ State _____ Zip Code _____

12. Telephone ( ) _____

Furnishing of this blank is for the employee's convenience and is not an acknowledgment of liability or waiver of any right.