LABORERS' BENEFITS • ST. LOUIS

Weekly Disability Claim Form

Contact the office every Monday morning reporting your status before 10:00am at (314) 644-2777 ext. 2.

Part I: Member Information

Full Name: _____ Member ID#: _____
Last *First*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

I certify that I have been continuously disabled and unable to work since _____

I recovered or will recover sufficiently to go back to work on _____

Was this disability work related? YES ☐ NO ☐

Treating Physician's Name: _____ Phone : _____

CERTIFICATE AND AUTHORIZATION TO RELEASE INFORMATION

I hereby certify that the above information is true and correct to the best of my knowledge. I understand that a falsification or withholding of material facts may result in loss of benefits.
For the purpose of determining eligibility for benefit and claim processing, I hereby authorize the Greater St. Louis Construction Laborers' Welfare Fund to receive from and/or provide to medical practitioners, medically related facilities, insurance companies or like organizations of my employer, information as to any physical or mental condition of myself or my covered dependents. I know that I have a right to receive a copy of this authorization. I agree a photographic copy is valid as the original.

Signature: _____ **Date** _____

Part II: Treating Physician's Statement

Patient's Name _____ Date of Birth: _____

Diagnosis and Concurrent Conditions: _____

When did the patient first consult you for this condition? _____

Is condition related to a work-related injury? YES ☐ NO ☐

Is patient still under your care? YES ☐ NO ☐ Next Appointment Date: _____

To process this form, we must have complete dates listed below.
We understand the date may change however, we cannot accept "to be determined, ongoing", etc.

Patient is/was unable to work from _____ to _____

Patient recovered, or will recover to sufficiently return to his/her **regular job** on _____

Part II: Treating Physician's Information

Treating Physician's Name _____

Address: _____
Street Address

_____
City *State* *ZIP Code*

Phone: _____ Fax: _____

Signature: _____ **Date** _____

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