

Weekly Disability Claim Form

Construction Laborers Benefit Office
 2357 59th Street St. Louis, MO 63110
 Phone: 314-644-2777 Fax: 314-646-4440

***Please call every Monday morning reporting your status before 10:00 a.m.
 We cannot distribute a check if you are currently working. Thank you!**

PART I: MUST BE COMPLETED BY PARTICIPANT			
PARTICIPANT NAME	MEDICAL MEMBER ID#	EMPLOYER NAME	EMPLOYER PHONE #
HOME ADDRESS	CITY	STATE	ZIP
HOME PHONE #	WAS THIS DISABILITY WORK RELATED? YES[] NO[]	JOB TITLE	NUMBER OF HOURS IN REGULAR WORK WEEK?
I CERTIFY THAT I HAVE BEEN CONTINUOUSLY DISABLED AND UNABLE TO WORK SINCE _____ DATE			
I RECOVERED OR WILL RECOVER SUFFICIENTLY TO GO BACK TO WORK ON _____ DATE			
THE FIRST DAY I SAW THE DOCTOR WAS _____ DATE			
MY LAST TREATMENT WAS ON _____ DATE BY _____ DOCTOR			
Certification 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 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 as valid as the original.			
X _____ PARTICIPANT'S SIGNATURE			X _____ DATE

PART II: TO BE COMPLETED BY PHYSICIAN	
PATIENTS NAME	DATE OF FIRST VISIT FOR CURRENT CONDITION
DIAGNOSIS AND CONCURRENT CONDITIONS	
Is sickness or accident related to patient's employment? YES[] NO[]	
Date patient first consulted you for this condition?	INCEPTION DATE IF PREGANCY?
Considering the claimant's occupation, could claimant resume duties of his usual and customary work while continuing treatment YES[] NO[]	
If no, please explain why _____	
Is patient still under your care? YES[] NO[]	_____ LAST DATE SEEN _____ NEXT APPOINTMENT DATE
Patient was continuously disabled (unable to work) from _____ to _____	
The patient recovered, or will recover, sufficiently to return to his regular job on _____ DATE	
Dates of hospitalization from _____ to _____ Name of Hospital _____	
DATE	ATTENDING PHYSICIAN'S SIGNATURE
STREET	
PHONE	CITY STATE ZIP
TAX I.D. NUMBER	

