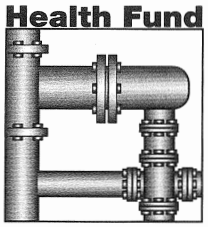

Connecticut Pipe Trades Health Fund
1155 Silas Deane Hwy
Wethersfield, CT 06109-4318
(860)571-9191 Fax (860)571-9221
www.connecticutpipetrades.com

Short Term Disability Claim Statement

To be completed by Plan Participant

Name: _____ _____ _____ PTH# _____ or SSN: _____ - ____- _____
(Last) (First) (M)
Address: _____
City: _____ State _____ Zip _____Phone: _____
E-mail: _____ Date of birth: _____ / _____ / _____ Male ☐ Female ☐

1. Cause of this disability: ☐ Accident ☐ Illness ☐ Pregnancy
2. Date you were first disabled by this injury or illness: _____ / _____ / _____ (mm/dd/yyyy)
3. Describe how and where accident occurred or list symptoms of illness and diagnosis

   _____
   _____
   _____

4. Was an accident involved? Yes ☐ No ☐ *(If No go to question 5)*
   A. When did this accident happen? _____ / _____ / _____ (mm/dd/yyyy)
   B. Where did the accident occur? _____
   C. Were you at work when the accident happened? Yes ☐ No ☐
   D. Brief description of the accident. _____

   _____

5. Are you receiving benefits from any of the following sources:
   Unemployment Compensation ☐ Workers Compensation ☐ Social Security Retirement ☐
   Social Security Disability ☐ Retirement or Pension Plan ☐ Other Sources ☐

6. **Acknowledgement**—I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief.

Signature _____ **Date**: _____ / _____ / _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Your treatment, ability to enroll in the Fund, eligibility for health plan benefits and/or payment for services will not be affected if you do not sign this form. (However, without your signature, your request to release the information described within to a third party will not be honored).

This protected health information provided under this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases, including HIV/AIDS and or genetic marker information. These records will be included in the information we will make available to the individual or class of individuals designated above.

Unless revoked earlier, this authorization will expire one year from the date you sign this authorization. If you sign this form, you may revoke the authorization at any time by notifying the Fund Administrator in writing at the address below. Your revocation is only effective after it is received and logged by the Fund Administrator. Revoking this authorization will not have any effect on actions taken by the Fund in reliance on this authorization prior to receiving such revocation.

You are entitled to receive a copy of this authorization from the Fund if you ask for it by writing to the address listed at the bottom of the page.

Signature _____ **Date**: _____ / _____ / _____

Please note, you may not receive Disability payments from CT Pipe Trades Health Fund for the same weeks you are receiving any other compensation. If you apply for and receive SSD Benefits with a retroactive payment, <u>any Disability payments made to you by the Health Fund for the same period as SSDI payment must be reimbursed to the Fund</u>

Attending Physicians Statement

Name: _____ PTH# _____ or SSN: _____ - ____- _____

1. Cause of Disability: Accident ☐ Illness ☐ Pregnancy ☐

2. Diagnosis & ICDA Classification: _____
_____
_____
_____
_____

3. History & Treatment
   A. Date you recommended the patient stop work. _____ / _____ / _____ (mm/dd/yyyy)
   B. Date symptoms appeared or accident happened. _____ / _____ / _____ (mm/dd/yyyy)
   C. Has the patient had same or similar condition? Yes ☐ No ☐ Date:_____ / _____ / _____
   D. Did this illness or injury arise from the patient's em- ☐ ☐ ployment? Yes No

   If Yes, please explain _____
   _____
   _____
   _____
   E. Nature of surgical procedure, or treatments, if any (describe fully) _____
   _____
   _____
   Date of treatments:
   Hospital _____
   Office _____
   Home _____

4. If pregnancy, what is the expected delivery date? _____ / _____ / _____

5. Your patient has been continuously disabled (unable to work) from _____ / _____ / _____

6. The patient was, or will be able to return to work on _____ / _____ / _____

7. Last follow up or next scheduled visit. _____ / _____ / _____

Physician's Name: _____
Address: _____
City _____
State & Zip _____
Phone & Fax _____ _____

Physicians Signature _____ **Date**: _____ / _____ / _____
I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief.