I.B.E.W. LOCAL UNION #124 HEALTH & WELFARE FUND
305 E. 103RD TERR
KANSAS CITY, MO 64114
SUPPLEMENTARY DISABILITY CLAIM
Office 816-943-0277 Fax 816-943-8983

THIS FORM MUST BE ENTIRELY COMPLETED BY EMPLOYEE AND PHYSICIAN AND ONLY IF LOSS OF TIME IS INVOLVED

TO BE COMPLETED BY EMPLOYEE

EMPLOYEE'S NAME____LAST 4 OF SSN _____________

DOB________________________________PHONE#____

EMPLOYED BY____

Is this disability claim work related?
YES
NO____

YOU WILL RECEIVE A W-2 AT THE END OF THE YEAR FOR THESE BENEFITS.

Are you still disabled? If not, when did you recover?
YES
NO____

If disabled due to an accident, please give accident information including date of injury_____________________________________

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Have you received any wages for work you have done during period for which you have received weekly benefits from t his Health and Welfare Fund? If yes, please indicate period of time worked and amount of wages received.
YES
NO______________________________

Have you received unemployment insurance benefits during any period for which you have claimed disability benefits?
YES
NO______________________________

Have you received any Workmen's Compensation Benefits in connection with this disability?
YES
NO______________________________

I hereby certify that the foregoing statements, including any accompanying statements, are true, correct, and complete to the best of my knowledge and hereby further authorize my attending physician, practitioner or hospital in which confinement took place to furnish and disclose all facts concerning my physical condition that are within their knowledge.

Date__________________________Signature____

To be Completed by the Health and Welfare Office Only

Members ID #____

Has employee returned to work? If yes, when.____

Do you have any information indicating the above employee is no longer disabled? If yes explain.

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Group IBEW Local Union 124 H&W Fund

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Patient's Name____DOB__________________

Nature of sickness or injury (Describe complications, if any)__________________________________

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Date of first treatment____

Date of most recent treatment____

Frequency of treatments____

The patient has been continuously disabled (unable to perform the duties of an electrician)

From__________________ Through ______________________

If still disabled, when should patient be able to return to work?___________________________

Remarks____

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Date____

Attending Physician Signature____

Physician Printed Name____

Physician Address and Phone #____

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