Five Rivers Health & Welfare Fund
5001 J Street S.W. Suite 100
Cedar Rapids, Iowa 52404
319-366-3623
1-800-847-0113

DISABILITY CLAIMS ONLY

CLAIM FOR DISABILITY BENEFITS

INSURED'S STATEMENT

1. Insured's full name _____ Age _____ Sex ☐Male ☐Female Social Security No. _____

Street and No. _____ City _____ State _____ Zip Code _____

2. Date insured _____ Occupation _____

3. Date sickness began or injury occurred _____ Date last worked _____

4. Date of first treatment by a physician in present disability _____

5. State fully nature of sickness or injury _____

6. If injured, state fully, how and where the injury occurred _____

_____ Did injury occur while on duty? Yes☐ No☐

7. From and to what dates were you continuously totally disabled and prevented from performing any work?

From _____ 20____, to _____ 20____

8. Date you were first able to do any work? _____

9. Has claim been filed or will claim be filed under any Worker's Compensation Act or similar law? Yes☐ No☐

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, in Florida, a felony of the third degree.

I hereby authorize any hospital, physician, or surgeon to furnish the Five River Carpenter Health & Welfare Fund any information desired.

Date _____ 20____ (Signed) _____
(Insured)

ATTENDING PHYSICIAN'S STATEMENT

Patient's name _____ Age _____

1. Nature of sickness or injury (Describe complications if any) _____

_____ ICD-9 Code No. _____

2. Did this sickness or injury arise out of patient's employment? Yes☐ No☐

If "yes" explain _____

3. Is disability due to pregnancy? Yes☐ No☐

If "yes," what was approximate date of commencement of pregnancy? _____ 20____

4. Nature of surgical or obstetrical procedure, if any. (Describe fully) _____

_____

_____

Date performed _____ 20____

5. Give dates of treatments:

Office _____

Home _____

Hospital _____

6. The patient has been continuously disabled (unable to work) from _____ 20____ through _____ 20____

If still disabled, when should patient be able to return to work? _____ 20____

7. Remarks: _____

Date	Attending Physician's Signature	MUST BE FURNISHED UNDER AUTHORITY OF LAW
		Individual Practitioner's SS No.
		All Others — Employer ID No.

Street Address	City or Town	State	Zip Code

Phone #