Plumbers & Pipefitters Local Union 344
Short Term Disability/Sick Leave Employee's Statement

Section A: Employee's Statement

1 General Information

Provide your full address and Social Security number.

Please print clearly

Your name (first, middle initial, last) ◻ M ◻ F		Social Security number	Date of birth
Your street address	City	State	Zip Code
Your Classification		Telephone Number	
Employer Name			

2 Information About the Condition Causing Your Disability

Reminder: Return completed claim packet (including Attending Physician Statement) and all required documentation to:

Plumbers & pipefitters
Local Union 344
Attn: Benefits Administrator
4337 S.W. 44th Street
Oklahoma City, OK 73119

Type (check one): ◻ Pregnancy ◻ Motor vehicle accident ◻ Work-related injury/sickness ◻ Sickness ◻ Other accident

Describe in detail how, when and where the accident occurred –OR – Describe the nature of your illness/condition and its first symptoms. If work-related, describe cause of injury/illness.		
Date you were first treated by a physician	Last day worked prior to disability	Did you work a full day? ◻ Yes ◻ No
Name of your first treating physician	Physician phone number	
Name of hospital	Hospital phone number	Date(s) of confinement
Date first unable to work	Date you expect to return to work	

If work-related, have you filed/do you intend to file, a Workers' Compensation claim? ◻ Yes ◻ No

3 Information About Other Income

Check all that apply and provide details for each source of income.

Are you currently receiving, or entitled to receive, benefits from any of the following sources?

Source of Income	Provider	Amount of each payment	Weekly or monthly	Period/date(s) covered by payment
◻ Vacation pay		$	◻ Wkly ◻ Mthly	
◻ Sick pay		$	◻ Wkly ◻ Mthly	
◻ Other disability		$	◻ Wkly ◻ Mthly	
◻ Other:		$	◻ Wkly ◻ Mthly	

4 Signature

Reminder: Please be sure to sign and return any Authorization statements included in this packet.

I certify that the above statements are true and complete. I have read and understand the Fraud Warning included in this packet.

Employee's signature	Date signed
X	

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Section B: Attending Physician's Statement

1 Information About the Patient

Please print Clearly

Provide your full address and Social Security number.

The patient is responsible for any costs associated with the completion of this form.

Your name (first, middle initial, last) ☐ M ☐ F	Social Security number	Date of birth (m/d/y)
Name of Employer: Plumbers & Pipefitters Local Union 344	Employee E-mail	Employee phone no.

2 Diagnosis and History

Provide general information about diagnosis and history in this section. Then, please elaborate in section(s) 3 – 6 as appropriate.

Diagnosis including any complications and ICD-9 Codes(s)	
Objective findings (i.e. x-rays, EKGs, MRIs, laboratory data and any other clinical findings)	
Subjective Symptoms	
Date symptoms first appeared or date of accident	Date Disability Commenced
Has patient ever had same or similar condition? ☐ Yes ☐ No If Yes, when:	
Is condition due to injury/sickness arising out of patient's employment?.... ☐ Yes ☐ No ☐ Unknown	
Names and telephone numbers of Other Treating Physicians (if applicable)	
If pregnancy, please provide the following information: • Expected delivery date: ___________ • Actual delivery date: ___________ • C-Section? Yes No	
Describe any complications that would extend this disability longer than a normal pregnancy	

3 Treatment

Include in description any surgery, therapeutic modalities, psychological intervention and medications prescribed.

Date of first visit	Date of last visit	Date of last examination
Frequency of treatment ….☐ Weekly ☐ Monthly ☐ Other (please specify: __________)		
Description of treatment		

4 Progress

Has patient:…..: □ Recovered □ Unchanged □ Improved □ Retrogressed
Is patient:…….. □ Ambulatory □ Bed confined □ House confined □ Hospital confined

If unchanged or retrogressed, please explain:		
Has patient been hospital confined? □ Yes □ No	From:	To:
If yes, provide name and address of hospital		

5 Restrictions and Limitations

Restrictions and Limitations should be associated with the Objective and Subjective findings/symptoms noted in Section 2.

Restrictions (what the patient should not do)
Limitations (what the patient cannot do)

Indicate class of physical impairment.

Physical Impairment
□ Class 1 – No limitation of functional capacity; capable of heavy work* No restrictions (0-10%)
□ Class 2 – Medium manual activity* (15-30%)
□ Class 3 – Slight limitation; capable of light work* (35-55%)
□ Class 4 – Moderate limitation; capable of clerical/administrative (sedentary)* activity (60-70%)
□ Class 5 – Severe limitation ; incapable of minimum (sedentary*) activity (75-100%)

*as defined in federal dictionary of occupation titles.

*If the Participant can not perform Class 1 work duties, he/she qualifies for Short Term Disability.

6 Return-to-Work

1. When will patient recover sufficiently to perform duties? (specify date or check recovery period)

7 Certification and Signature

Remember to provide your full address and Tax ID number.

I certify that the above statements are true and complete.

A stamp or signature of a person other than the examining physician is not acceptable.

Name of Attending Physician	Degree/Specialty		
Street Address	City	State	Zip Code
Tax ID Number	Telephone Number		Fax Number
Attending Physician Signature **X**			Date

Plumbers & Pipefitters Local Union 344
Short Term Disability/Sick Leave Employee's Statement

This Authorization complies with the HIPAA Privacy Rule. It is important for you to read, sign and submit all Authorizations in this packet. Failure to submit all Authorizations could result in a delay during the claims process.
Return to:

Plumber & Pipefitters Local Union 344
Attn: Benefits Administrator
4337 S.W. 44th Street
Oklahoma City, OK 73119

I HEREBY AUTHORIZE any physician, health care provider, health plan, medical professional, hospital, clinic, laboratory, pharmacy or other medical or healthcare facility that has provided payment, treatment or services to me or on my behalf, to disclose my entire medical record and any other protected health information concerning me to the Benefits Office of Plumbers & Pipefitters Local Union 344 its subsidiaries, affiliates, third party administrators and attorney.

I understand that such information may include records relating to my physical or mental condition such as diagnostic tests, physical examination notes and treatment histories, which may include information regarding the diagnosis and treatment of human immunodeficiency virus (HIV) infection, sexually transmitted diseases, mental illness and the use of alcohol, drugs and tobacco, but shall not include psychotherapy notes.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization, and I instruct any physician, health `care professional, hospital, clinic, medical facility or other health care provider to release and disclose my entire medical record without restriction.

I understand that the Union will use the information it obtains to (a) administer claims; (b) determine or fulfill responsibility for coverage and provision of benefits; (c) administer coverage; and/or (d) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Union.

I understand that the Union will not disclose information it obtains about me except as authorized by this Authorization; as may be required or permitted by law; or as I may further authorize. I understand that if information is redisclosed as permitted by this Authorization, it may no longer be protected by applicable federal privacy law.

I understand that: (a) this Authorization shall be valid for 24 months from the date I sign it; (b) I may revoke it at any time by providing written notice to Benefits Administrator Plumbers & Pipefitters Local Union 344, subject to the rights of any person who acted in reliance on it prior to receiving notice of its revocation; and (c) my authorized representative and I are entitled to receive a copy of the Authorization upon request.

A copy of this Authorization shall be as valid as the original.

Print Name of Employee or Personal Representative of Employee	
If Representative, description of your authority of relationship to employee	
Signature of Employee of Personal Representative **X**	Date

PRIVACY INFORMATION NOTICE

This notice explains why Plumber & Pipefitters Local Union 344 ("the Union") collects personal information about you, how we use that information, and under what circumstances we disclose it to others.

COLLECTION OF INFORMATION

We need to obtain information about you to determine whether we can provide the benefits you have requested. As part of the claims process, we may ask you to undergo a physical examination, submit a statement from your physician, or provide copies of medical tests or other information relating to your health, finances and activities.

We also may collect information about you from other sources. By signing the Authorization For Release And Disclosure of Health Related Information and/or the Authorization For Release And Disclosure of Psychotherapy Notes, you authorize us to obtain medical information about you that we need to underwrite your application. Depending upon your particular circumstances, we may collect additional information about you from the following sources:

- Physicians, health care providers, medical professionals, hospitals, clinics or other medical or health care related facilities
- Other insurance companies you have applied to for insurance
- Public records, such as Social Security and tax records

DISCLOSURE OF PERSONAL INFORMATION

When you sign the Authorization For Release And Disclosure of Health Related Information and/or the Authorization For Release And Disclosure of Psychotherapy Notes, you authorize us to disclose information we have about you:

- To our reinsurers
- As required or permitted by law

In the course of the claims process, we may need to disclose information about you to others. The law permits us to disclose such information, without obtaining authorization from you, to:

- Companies that help us conduct our business or perform services on our behalf
- Your physician or treating medical professional
- Comply with federal, state or local laws, respond to a subpoena or comply with an inquiry by a government agency or regulator

ACCESS, CORRECTION AND AMENDMENT OF PERSONAL INFORMATION

Upon written request to the Company, you can:

- Obtain a copy of the personal recorded information we have about you in our files (a fee may be charged to cover the cost of providing a copy of such information)
- Request that we correct, amend or delete any recorded personal information about you in our possession
- File your own statement of facts if you believe that the recorded personal information we have about you is incorrect

To take any of these actions, please contact us at the following address for further instructions:

Plumbers & Pipefitters

Local Union 344

Attn: Benefits Administrator

4337 S.W. 44th Street
Oklahoma City, OK 73119