WISCONSIN ELECTRICAL EMPLOYEES BENEFIT FUNDS
2730 DAIRY DRIVE SUITE 101
MADISON WI 53718
(608)276-9111 OR (800)422-2128
FAX (608) 288-9103

DISABILITY CLAIM FORM
EMPLOYEE, PHYSICIAN & EMPLOYER
STATEMENT MUST ALL BE COMPLETED IN FULL.

EMPLOYEE STATEMENT (print or type all answers)

NAME OF EMPLOYEE:_____ SS#_____

ADDRESS: _____TELEPHONE:_____

STATE/ZIP _____DATE OF BIRTH:_____

CLAIM FOR (check one) _____ ILLNESS _____ACCIDENT/INJURY _____INPATIENT HOSPITAL

DATE ILLNESS/CONFINEMENT OR INJURY BEGAN:_____

IF ACCIDENT/INJURY, DESCRIBE IN DETAIL HOW, WHEN AND WHERE IT HAPPENED:_____
_____
_____

DID ILLNESS/CONFINEMENT OR ACCIDENT/INJURY HAPPEN AS A RESULT OF OR IN COURSE OF YOUR EMPLOYMENT FOR ANY EMPLOYER FOR COMPENSATION, WAGE OR PROFIT? _____ YES _____NO

IF YES, HAS A CLAIM BEEN FILED WITH WORKMAN'S COMPENSATION? _____YES _____NO NAME OF EMPLOYER YOU WERE WORKING FOR WHEN ILLNESS /CONFINEMENT OR INJURY HAPPENED.
_____
_____

IS THIS ACCIDENT/INJURY CLAIM ELIGIBLE FOR COMPENSATION UNDER ANY HOMEOWNERS OR AUTO INSURANCE POLICY? _____ YES _____ NO IF YES PLEASE PROVIDE INSURANCE INFORMATION:
_____

ARE BENEFITS FOR WHICH THIS CLAIM IS FILED COVERED BY ANY OTHER GROUP OR GOVERNMENT HEALTH OR DISABILITY INSURANCE? YES NO IF YES, NAME, ADDRESS AND POLICY NUMBER OF OTHER CARRIER: _____

WERE YOU TERMINATED OR LAID OFF PRIOR TO DISABILITY? YES / NO IF YES, ARE YOU COLLECTING UNEMPLOYMENT? IF YES PLEASE INPUT THE LAST PERIOD FOR WHICH YOU COLLECTED UNEMPLOYMENT THROUGH **(CANNOT COLLECT BOTH UNEMPLOYMENT AND DISABILITY AT THE SAME TIME)**.
UNEMPLOYMENT PAID THROUGH:_____

DATE OF FIRST MEDICAL ATTENTION FOR ILLNESS/CONFINEMENT OR INJURY:_____

DATE FIRST UNABLE TO WORK: _____

DATE RETURNED OR AVAILABLE TO RETURN TO WORK: _____

I CERTIFY THAT THE INFORMATION CONTAINED ABOVE IS VALID AND TRUE, TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT ANY WILLFULLY FALSE STATEMENTS ON THIS FORM CAN BE PUNISHED BY FINE AND IMPRISONMENT (U.S. CODE TITLE 18, SECTION 1027).

EMPLOYEE SIGNATURE_____**DATE**_____

AUTHORIZATION FOR RELEASE

I HEREBY AUTHORIZE ANY INSURER, HOSPITAL, PHYSICIAN, DENTIST, CONSUMER REPORTING AGENCY, EMPLOYER, GROUP POLICY HOLDER OR OTHER PERSON, COMPANY OR ORGANIZATION WHO HAS ATTENDED OR EXAMINED OR HAS RECORDS PERTAINING TO ME TO FURNISH WISCONSIN ELECTRICAL EMPLOYEES HEALTH AND WELFARE PLAN, OR THEIR REPRESENTATIVE ANY AND ALL INFORMATION WITH RESPECT TO ANY ILLNESS, INJURY OR DENTAL CARE, MEDICAL HISTORY, CONSULTATION, PRESCRIPTION OR TREATMENT, AND COPIES OF ALL HOSPITAL, MEDICAL OR DENTAL RECORDS AND ALL OTHER SUCH INFORMATION REQUESTED IN ORDER TO ASSIST WISCONSIN ELECTRICAL EMPLOYEES HEALTH AND WELFARE PLAN IN DETERMINING MY ELIGIBILITY FOR DISABILITY BENEFITS.

ANY INFORMATION OBTAINED THAT IS SUBJECT TO APPLICABLE PRIVACY LAWS WILL NOT BE RELEASED BY THE WISCONSIN ELECTRICAL EMPLOYEEES HEALTH AND WELFARE PLAN TO ANY PERSON OR ORGANIZATION EXCEPT TO RE-INSURING COMPANIES, THE MEDICAL INFORMATION BUREAU, INC., MY EMPLOYER, GROUP POLICY HOLDER OR OTHER PRESONS OR ORGANIZATIONS PERFORMING BUSINESS OR LEGAL SERVICES IN CONNECTION WITH MY CLAIM, OR MAY BE OTHERWISE LAWFULLY REQUIRED OR AS I MAY FURTHER AUTHROIZE.

I UNDERSTAND THAT:

- THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN IT.
- I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BEFORE ITS EXPIRATION DATE BY SENDING A WRITTEN NOTICE TO EACH ENTITY THAT I PREVIOUSLY AUTHORIZED TO DISCLOSE HEALTH INFORMATION., THE REVOLCATION WILL NOT HAVE ANY EFFECT ON ANY ACTIONS THAT THE ENTITY TOOK BEFORE IT RECEIVED THE REVOCATION NOTICE.
- I AM NOT REQUIRED TO SIGN THIS AUTHORIZATION AS A CONDITION TO RECEIVING TREATMENT OR PAYMENT FOR HEALTH CARE; ENROLLING IN A HEALTH PLAN; OR ESTABLISHING ELIGIBILITY FOR HEALTH BENEFITS.
- THE INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE REDISCLOSED BY THE RECEIVING PERSON OR ORGANIZATION AND, UPON REDISCLOSURE, MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY LAWS.
- I MAY REQUEST TO RECEIVE A COPY OF THIS AUTHORIZATION. I AGREE A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORGINAL.
- THIS AUTHORIZATION SHALL BE VALID FOR TWO AND ONE HALF YEARS FROM THE DATE SHOWN BELOW.

EMPLOYEE SIGNATURE: _____ **DATE:**_____

EMPLOYER STATEMENT
(print or type answers)

I HEREBY CERTIFY THAT I AM AN OWNER (OR SUPERVISOR) AT _____

MY EMPLOYEE _____ HAS APPLIED FOR DISABILITY PAYMENT FROM

WISCONSIN ELECTRICAL EMPLOYEES HEALTH & WELFARE PLAN. OUR RECORS INDICATE THIS EMPLOYEE WAS FIRST

UNABLE TO WORK ON _____ AND HE/SHE RETURNED TO WORK

ON _____. HE/SHE WAS LAST PAID A SALARY/WAGE UNTIL _____

WAS EMPLOYEE TERMINATED OR LAID OFF PRIOR TO DISABILITY? YES / NO IF YES, DATE:_____

NAME OF INDIVIDUAL COMPLETING FORM:_____

SIGNATURE:_____

TITLE_____ DATE_____

ATTENDING PHYSICIANS STATEMENT
(print or type answers)

PATIENTS NAME:_____ SEX:_____MALE_____FEMALE

IS CONDITION RELATED TO:

PATIENT'S EMPLOYEMENT	_____YES	_____NO
AUTOMOBILE ACCIDENT	_____YES	_____NO
OTHER ACCIDENT	_____YES	_____NO

IF YES,

EXPLAIN:_____

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY:_____

_____

_____

DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY/ACCIDENT:_____

DATE FIRST CONSULTED FOR THIS CONDITION:_____

HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? _____YES _____NO

DATE PATIENT FIRST UNABLE TO WORK:_____

DATE PATIENT ABLE TO RETURN TO WORK:_____

IF NOT ABLE TO RETURN TO WORK, NEXT DOCTORS APPOINTMENT:_____

IF HOSPITALIZED, GIVE HOSPITALIZATION DATES:_____

PROVIDER NAME:_____TAX ID#_____

ADDRESS:_____

TELEPHONE NUMBER:_____

PROVIDER SIGNATURE:_____ DATE:_____