TEAMSTERS LOCAL 301 H&W FUND

36990 N. Green Bay Road Waukegan, IL 60087 • (847) 623-5430 • Fax (847) 623-5795

Return this complete form by mail to the address above or by fax. You can find directions on how to upload your completed document on our web portal at www.teamsters301HWP.org located at the bottom of the screen.

SHORT-TERM DISABILITY & FRATERNAL DUES REBATE APPLICATION

SECTION 1: TO BE COMPLETED BY THE EMPLOYEE

Last Name:	First Name:	Middle Initial:	Birthdate:

Street Address:	City:	State:	ZIP Code:

Phone Number:	Social Security Number:	Employer Name:

Date you last worked due to your disability	Date you returned to work	If not yet returned, date you expect to return

Disability due to: ☐ Illness ☐ Injury Type of Injury: ☐ Auto ☐ Worker's Compensation ☐ Home ☐ Other

The above statements are true and complete to the best of my knowledge and belief. (Your signature is required for benefit consideration.)

Signature of member:	Date

SECTION 2: TO BE COMPLETED BY THE EMPLOYER

Date employee last worked: _____

Date employee returned to work: _____

Please indicate if any of the time off was vacation time or paid sick leave:

_____/_____/_____ to _____/_____/_____

Did injury or illness arise out of or in course of employment: ☐ Yes ☐ No

Is this worker on lay off status: ☐ Yes ☐ No

Printed Name of Employer Representative:	Title:	Phone Number:

Signature of Employer Representative:	Date

SECTION 3: TO BE COMPLETED BY PHYSICIAN

Current diagnosis:

Has patient ever had same or similar condition: ☐ Yes ☐ No
If yes, please specify dates of treatment:

Was patient hospitalized: ☐ Yes ☐ No
If yes, please provide dates of confinement and name of hospital/facility:

Did injury or illness arise out of or in course of employment:
☐ Yes ☐ No ☐ Unknown

TREATMENT

The patient has been continuously disabled (unable to work) From ____/____/____ through ____/____/____	Date of first visit	Date of next visit

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

Remarks:

Signature of physician X	Date