Weekly Disability Claim Form

Construction Laborers Benefit Office
2357 59th Street St. Louis, MO 63110
Phone: 314-644-2777 Fax: 314-646-4440

***Please call every Monday morning reporting your status before 10:00 a.m.**
We cannot distribute a check if you are currently working. Thank you!

PART I: MUST BE COMPLETED BY PARTICIPANT

PARTICIPANT NAME	SOCIAL SECURITY NUMBER	EMPLOYER NAME	EMPLOYER PHONE #

HOME ADDRESS	CITY	STATE	ZIP

HOME PHONE #	WAS THIS DISABILITY WORK RELATED? YES[ ] NO[ ]	JOB TITLE	NUMBER OF HOURS IN REGULAR WORK WEEK?

I CERTIFY THAT I HAVE BEEN CONTINUOUSLY DISABLED AND UNABLE TO WORK SINCE _____
DATE

I RECOVERED OR WILL RECOVER SUFFICIENTLY TO GO BACK TO WORK ON _____
DATE

THE FIRST DAY I SAW THE DOCTOR WAS _____
DATE

MY LAST TREATMENT WAS ON _____ BY _____
DATE DOCTOR

Certification and authorization to release information:
I hereby certify that the above information is true and correct to the best of my knowledge. I understand that a falsification or withholding of material facts may result in loss of benefits.
For the purpose of determining eligibility for benefit and claim processing, I hereby authorize Greater St. Louis Construction Laborers' Welfare Fund to receive from and/or provide to medical practitioners, medically related facilities, insurance companies or like organizations of my employer, information as to any physical or mental condition of myself of my covered dependents. I know that I have a right to receive a copy of this authorization. I agree a photographic copy is as valid as the original.

X _____ X _____
PARTICIPANT'S SIGNATURE DATE

PART II: TO BE COMPLETED BY PHYSICIAN

PATIENTS NAME	DATE OF FIRST VISIT FOR CURRENT CONDITION

DIAGNOSIS AND CONCURRENT CONDITIONS

Is sickness or accident related to patient's employment? YES[ ] NO[ ]

Date patient first consulted you for this condition?	INCEPTION DATE IF PREGANCY?

Considering the claimant's occupation, could claimant resume duties of his usual and customary work while continuing treatment YES[ ] NO[ ]

If no, please explain why _____

Is patient still under your care? YES[ ] NO[ ] _____ _____
LAST DATE SEEN NEXT APPOINTMENT DATE

Patient was continuously disabled (unable to work) from _____ to _____

The patient recovered, or will recover, sufficiently to return to his regular job on _____
DATE

Dates of hospitalization from _____ to _____ Name of Hospital _____

_____ _____ _____
DATE ATTENDING PHYSICIAN'S SIGNATURE TAX I.D. NUMBER

_____
STREET

_____ _____ _____
PHONE CITY STATE ZIP