The Connecticut Carpenters Health Fund

DISABILITY CLAIM FORM

IMPORTANT: The Fund does not honor claims for work-related injuries.
Before filing claim, be sure ALL QUESTIONS are answered, or your claim will be delayed

CLAIM FORM TO BE FULLY COMPLETED BY THE MEMBER

A. Name of Member ______________________ Social Security number ____/____/____
First Middle Last

B. Address ____
Street Address City State Zip Code

C. Telephone Number (__________)____________________________ D. Date of Birth ___/___/___ Local ________

E. Are you currently receiving unemployment benefits?____Yes ___No If yes, when was your last check?___________

F. If accident, Date of Accident ______________________ Where did it occur?_________________________

How did accident occur? ____

Did accident involve someone else? _____Yes _____ No

G. Is your illness or injury related to your occupation? ____ Yes ____ No	If "Yes", then please explain: Have you, or do you intend to file a Workers Compensation claim? _____ Yes _____ No
Describe how and where injury occurred or describe the onset and nature of your illness.	

Authorization to Release Information. I hereby authorize the undersigned physician to release protected health information related to the treatment of and payment for the injury or illness described above to the Connecticut Carpenters Health Fund for the purpose of determining eligibility for disability income benefits. This authorization is valid for two (2) years from the date I sign. I understand the following: I can revoke this authorization at any time by writing to the Fund Office; the Health Fund cannot condition payment of benefits to me on receipt of this authorization; and there is a possibility that protected health information disclosed pursuant to this authorization could be re-disclosed by a future recipient.

Member Signature ______________________ Date ______________________

TO BE COMPLETED BY ATTENDING PHYSICIAN

I certify I attended (Name of Patient)	Date of Birth	Diagnosis	
Date Injury / Illness Began		Date First Treated	
Has patient ever had same or similar condition? ____ Yes ____ No If "yes" when and describe.		Is the patient still under your care for this condition? ____ Yes ____ No	
Patient was continuously totally disabled (unable to work) From: To:		If still disabled, date patient should be able to return to work	
Patient was house confined. From: To:			
Treated by:			
Date	Hospital Name	Street Address	City / State / Zip Code
Date	Physician's Name (Print)	Signature	Tax ID Number
Telephone #	Street Address	City / State / Zip Code	

REVISED 10/03