PSSU LOCAL UNIT HEALTH AND WELFARE FUND SHORT TERM DISABILITY BENEFIT

INITIAL CLAIMANT'S STATEMENT OF DISABILITY

EMPLOYEE NAME	DATE OF BIRTH	ID NUMBER (OFFICE USE ONLY)
ADDRESS	CITY/STATE/ZIP	TELEPHONE NUMBER (DAYTIME)
DATE LAST WORKED	FIRST DAY UNABLE TO WORK BECAUSE OF ILLNESS	WHAT IS THE DIAGNOSIS OF YOUR CONDITION?
IF DISABILITY IS DUE TO AN ACCIDENT, WHERE DID IT OCCUR? ☐ HOME ☐ WORK ☐ OTHER	DATE OF ACCIDENT / WAS THE ACCIDENT REPORTED TO THE POLICE? YES ☐ NO ☐	IF YES, WHAT IS THE ADDRESS OF THE POLICE DEPARTMENT?
IF INJURY WAS THE RESULT OF A MOTOR VEHICLE ACCIDENT WERE YOU THE DRIVER? ☐ YES ☐ NO	PLEASE PROVIDE DETAILS OF HOW ACCIDENT OCCURRED	
IF YOUR CONDITION IS WORK RELATED, WAS A WCB CLAIM FILED? ☐ YES ☐ NO	IF NO, PLEASE EXPLAIN:	

ARE YOU ENTITLED TO BENEFITS FROM:

☐ WORKER'S COMPENSATION ☐ STATE DISABILITY

☐ DISABILITY BENEFITS UNDER THE FEDERAL SOCIAL SECURITY ACT

☐ ANY PENSION PLAN ☐ AUTOMOBILE INSURANCE

☐ OTHER (PLEASE SPECIFY)

_____

IF YES, PLEASE INDICATE:

DATE BENEFITS COMMENCED _____

DATE BENEFITS TERMINATED _____

AMOUNT

$ _____

☐ WEEKLY ☐ MONTHLY

☐ BIWEEKLY ☐ LUMP SUM

LIST ALL PHYSICIANS CONSULTED DURING YOUR ILLNESS NAME AND ADDRESS	DATE CONSULTED	REASON

INDICATE NAME AND ADDRESS OF ALL HOSPITALS WHERE YOU RECEIVED TREATMENT FOR YOUR PRESENT ILLNESS AND THE DATES.

NAME	ADDRESS	DATES FROM TO

DOES YOUR ILLNESS STILL PREVENT YOU FROM WORKING? ☐ YES ☐ NO	IF NO, WHAT DATE DID YOU RETURN TO WORK?	IF YES, WHAT DATE DO YOU EXPECT TO RETURN TO WORK?

I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled and that the foregoing statements, including any accompanying statements , are to the best of my knowledge true and complete.

SIGN HERE →

Claim signed on _____ _____

DATE EMPLOYEE'S SIGNATURE