# DISTRICT COUNCIL 37 HEALTH & SECURITY PLAN

125 BARCLAY STREET, NEW YORK, N.Y. 10007

HS:DIS 013

Please Type or Print

## SHORT-TERM DISABILITY BENEFIT CLAIM

Phone: (212) 815-1234

**TO BE FULLY COMPLETED BY EMPLOYEE AND FILED WITHIN 15 DAYS FROM THE DAY YOU BECOME DISABLED REGARDLESS OF SICK, VACATION OR ANNUAL TIME.**

### EMPLOYEE INFORMATION

Name ______________________ Soc. Sec. No. ______________

Home Address ______________________________________________
No. & Street City State Zip

Date of Birth ______________ Male ☐ Female ☐ Home Phone ______________

### JOB INFORMATION

Name of your work place ______________________ Date of Employment ______________

Work Address ______________________ Timekeeper Personnel Phone No. ______________ Payroll

Department ______________________

Job Title ______________ If school worker, District Office No. ______________

Annual Salary ______________ Hours worked per day ______________

How many sick days did you have on the date you become disabled? ______________

### ILLNESS INFORMATION

When did you become totally disabled so that you could not work? Date: ______________

What date did you first see a doctor? ______________ Name of doctor ______________

Describe your illness ______________________________________________

Have you returned to work yet? Yes ☐ No ☐ If yes, what date? ______________

Have you ever received disability payments for the same illness? Yes ☐ No ☐ If yes, what year? ______________

**IF CONFINED IN HOSPITAL**

Name of Hospital ______________________________________________

Address of Hospital ______________________________________________

Date Admitted ______________ ☐ AM ☐ PM Date Discharged ______________

**IF DISABILITY IS DUE TO ACCIDENT**

A. Date of accident ______________ ☐ AM ☐ PM B. How did it happen? ______________

C. Did it happen at work? Yes ☐ No ☐ D. Did you file for Workers' Compensation? Yes ☐ No ☐

E. Is there a lawsuit? Yes ☐ No ☐

F. If yes, give attorney's name ______________________________________________

Address ______________________ Phone No. ______________

### SIGN HERE

The above statements are true and complete to the best of my knowledge and belief and I hereby authorize any hospital or physician who has treated me to furnish any and all medical information to District Council 37 Health and Security Plan.

Signature ______________________ Date ______________
(SIGNATURE ONLY—DO NOT PRINT)

**IF YOU ARE PLANNING TO GO OUT OF THE NEW YORK AREA AFTER YOU HAVE APPLIED FOR DISABILITY BENEFITS, YOU MUST CONTACT THE HEALTH & SECURITY PLAN OFFICE OR YOUR CLAIM WILL BE DECLARED INELIGIBLE.**

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**(212) 815-1234**

## ATTENDING PHYSICIAN'S STATEMENT

**Patient**__________ **Claim No.**__________ **Age**_____ **Sex**_____

DIAGNOSTIC CATEGORY

**A. Medical Conditions/Diagnosis**

***(IMPORTANT:*** **THIS CLAIM CANNOT BE PROCESSED WITHOUT THE APPROPRIATE ICD CODES.*)***

| | ICD CODE | DESCRIPTION |
|---|---|---|
| Primary Diagnosis | ____.___ | __________ |
| Secondary Diagnosis | ____.___ | __________ |
| | ____.___ | __________ |

Is patient's disability related to Substance Abuse YES ☐ NO ☐ and/or Alcoholism YES ☐ NO ☐

Is patient's disability related to an accident? YES ☐ NO ☐

Is patient's disability a result of an injury arising out of and in the course of employment or an occupational disease? YES ☐ NO ☐

TREATMENT INFORMATION

**B. Specific Dates of Treatment for this Illness:** _____; _____; _____; _____; _____

If hospitalized for this disability: Date Admitted__________ Date Discharged__________

Name of Hospital:__________ Address:__________

If surgery was performed, give the date(s): __________

Type of Surgery: *(with CPT code)*__________

If pregnancy, list date, or expected Date of Delivery: __________

Type of delivery: Normal ☐ C-Section ☐

Are there other disabling conditions accompanying this pregnancy? YES ☐ NO ☐

If yes, please list::__________

**C. Therapy**

Is patient receiving Chemotherapy, Radiation or on Dialysis? YES ☐ NO ☐

If yes, give dates: _____; _____; _____; _____; _____; _____; _____; _____

Is patient receiving Physical Therapy? YES ☐ NO ☐

If yes, give dates: _____; _____; _____; _____; _____; _____; _____; _____

Is patient in a program for Substance Abuse? YES ☐ NO ☐

Name of Program__________ Telephone Number__________

Dates in attendance: _____; _____; _____; _____; _____; _____; _____

**D. Anticipated Duration For This Disability**

(Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)

Patient's disability is expected to extend from__________ through__________

SIGN HERE

| Physician's Signature | Name (Print) | Degree Specification |
|---|---|---|
| Licensed in the State of | License Number | |
| Address | Phone | Date |

REV:5/98