CLAIM FOR SUPPLEMENTAL WEEKLY DISABILITY BENEFITS
SUPPLEMENTAL PLAN OF THE PIPE TRADES INDUSTRY HEALTH AND WELFARE PLAN

P.O. BOX 3040 – TERRE HAUTE, INDIANA 47803
Telephone: - a/c 812-877-2581

Toll Free: 1-800-837-5678
FAX# 812-877-4542

THIS PART TO BE COMPLETED BY EMPLOYEE: YOUR LOCAL UNION NO. ________________

Employee's Name ____________________________________ Identification No. __________________________

Address ____ Phone No. _________________________________

DATE DISABILITY BEGAN ____________________________

Was disability job related? ____

If disability is due to an accident, describe briefly what happened: ____

____

Have you worked since sickness commenced? _______ **If so, list dates worked:**______________________________

Are you working now? ________ **I certify that I was unable to work due to sickness or injury during the week(s) beginning**

__________________________ **and ending** __________________________**, and I further certify that I did not, or will not, receive compensation from my employer during this period.**

In the case of a claim for the Weekly Disability Benefit, the week(s) for which you are claiming benefits must have passed. Multiple weeks may be included on a single claim form only when properly certified by the attending physician for a period prior to the date signed by the doctor. Benefits are payable on the basis of seven (7) day periods. Benefits for part-weeks will be computed on the basis of $1/7^{th}$ of the weekly benefit per day. In the case of sickness, you WILL NOT be paid for the first seven (7) days; however, a form properly certifying that you were under the care of a doctor during that week must be filed. Each form must be signed by a doctor who verifies that you were unable to work during the period for which you are claiming benefits. **ALL CLAIMS MUST BE FILED WITHIN 90 DAYS OF THE FIRST DAY OF DISABILITY.**

SIGNED ____
(EMPLOYEE'S SIGNATURE)

DOCTOR'S REPORT: (Not to be completed until Employee completes above section)

Physician's Name ____Phone No. ____________________________

Address: ____

Date unable to work due to disability __________________________Date Released ________________________

Diagnosis of disability: ____

I certify the above named individual was unable to perform work of his trade during the week(s) designated above.

Date __________________________________ SIGNED ____
(PHYSICIAN'S SIGNATURE)

TO BE COMPLETED BY THE EMPLOYER:

Weekly wage (excluding overtime pay, commissions, bonuses) $_______________________________________

Date last worked__________________________ Date returned to work ___________________________________

Is member claiming or receiving worker's compensation? __________Yes __________No

Date __________________________________ Employer Signature____________________________________

DO NOT WRITE IN THIS SPACE – FOR OFFICE USE ONLY

Amount ____________________**No. of weeks** ___________ **Payment No.** ___________