# SHORT-TERM DISABILITY CLAIM FORM

Toledo Electrical Welfare Fund – P.O. Box 60408, Rossford, Ohio 43460
Phone: 419-666-4450 Fax: 419-666-5410 Email: disability@electricalfunds.org

## THIS SECTION TO BE COMPLETED BY MEMBER

Full Name: _____ Last four of your SSN: _____

Address:

Phone: Date of Birth:

Last day worked before disability: _____ Date disability began: _____

Is your disability work related? _____If yes, have you filed a Workers' Compensation Claim? _____

Is your disability related to a motor vehicle accident and/or is a third party liable? _____

If yes, a Subrogation Form may be required to complete before this claim can be considered.

Type of Disability: ☐ Accident ☐ Illness / Other ☐ Pregnancy -- Estimated Due Date: _____

**If Illness/Other**, describe symptoms and date they began **OR if accident**, describe when, where and how it occurred:

_____

_____

***I realize to falsify information to the TEWF is considered a fraudulent act against the Fund. A fraudulent act may result in denial of eligibility under the benefit plans.***

**Member Signature: _____ Date of Signature _____**

## THIS SECTION TO BE COMPLETED BY THE ATTENDING PHYSCIAN

The following information is required to document the patient's inability to work and to process this disability claim.
The member is responsible for obtaining a completed form without expense to TEWF. Please return by fax, mail, or email.

Is this patient under your care for the above disability? ☐ Yes ☐ No If Pregnancy, est. delivery date: _____

ICD-10 Diagnosis code: _____ Description: _____

_____

Date you first recommended patient to stop work: _____ First visit for this disability: _____

Next follow up appointment: _____ Has patient ever had the same or similar condition? ☐ Yes ☐ No

If yes, describe and list dates: _____

Describe patient's physical and/or mental limitations and restrictions: _____

_____

How long will patient be unable to work due to the above? From: _____ To: _____

Name of physician: _____ Tax ID: _____

Address: _____

Phone: _____ Fax: _____

***I certify the answers I have made to the above questions are complete and true to the best of my knowledge and belief.***

Physician's Signature Date of Signature