BEER INDUSTRY – LOCAL UNION NO. 703 Health and Welfare Fund
18660 Graphic Drive, Suite 202, Tinley Park, IL 60477
T: (708) 429-0046 F: (708) 429-0047

This area completed by BEER INDUSTRY 703 only
Date Form Mailed:
_____

DISABILITY CLAIM FORM

Participant's Name	**Last four SSN / Unique Identification No. (UID)**	**Date of Birth**
Describe sickness or injury. If injury, how and where did it occur?		
Did illness or accident occur at work? _____Yes _____No	**Date illness/accident occurred.**	**Date Last Worked.**

_____ _____
Participant's Signature **Date**

EMPLOYER'S INFORMATION (to be completed by EMPLOYER)

1. **On what date did employee last work prior to his/her disability?** _____
2. **Is this disability due to, or the result of, an illness/injury arising out of, or in the course of, employment?** _____
3. **If the cause of disability was occupational, has it been reported to the State Board of Commission or any insurance company as a worker's compensation claim?** _____
4. **Indicate type of leave: FMLA _____ Sick Leave _____ Leave of Absence _____ Workers Comp _____ Other _____**
5. **If the employee has returned to work, please indicate the date of return:** _____

EMPLOYER NAME: _____ **TELEPHONE NUMBER**: _____
NAME/TITLE OF REPRESENTATIVE COMPLETING THIS FORM: _____

STATEMENT OF ATTENDING PHYSICIAN

Patient's Name	**IS/WAS PATIENT UNABLE TO WORK?** **Date patient is able to return to work:**
Date of total disability **from through**	**Date first consulted for this condition** **Date of out-patient surgery**
Dates of illness (first symptoms) or injury (accident)	**HOSPITALIZATION** **Admission Date** / **Discharge Date**
ICD-10 CODES AND DESCRIPTIONS OF DIAGNOSIS	
1. _____ 2. _____	3. _____ 4. _____
Physician's Name, Address, and Telephone Number (print)	

PHYSICIAN SIGNATURE: _____ **DATE**: _____

PARTICIPANT AUTHORIZATION TO RELEASE OF INFORMATION:

Authorization: I hereby authorize any hospital, physician, or other person, company or organization who has attended or examined me or who has records pertaining to the information pertaining to this DISABILITY CLAIM FORM to furnish Beer Industry Local Union No. 703 or their representatives, any and all information with respect to any illness, injury care, medical history, consultation, prescription or treatment, and copies of all hospital, medical records and all such other information requested. I understand that in executing this authorization I waive the right for such information to be privilege. A photocopy of the authorization shall be considered as effective and as the original.

_____ _____
Participant's Signature **Date**