TimeKeeper's Phone # ______________________

**CWA Local 1182 Security Benefit Fund**
58-38 69th street, 2 Front, Maspeth, New York 11378

**Group Disability Claim for Short Term Disability Benefits**

**CLAIM #**

**"Notice to All Parties Completing this Form: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts."**

## *CLAIMANT'S STATEMENT*

Your name (Please print) ______________________ Sex ☐M ☐F Social Security # ______________ Date of Birth __/__/__

Your home address

No. Street City State Zip Home Telephone #

Your mailing address (if different from home address)

No. Street City State Zip

Nature of sickness or injury ______________ Date first treated for this sickness or injury __/__/__

If due to accident, give date of accident __/__/__ Where and how did accident occur? ______________

Name(s) and address(es) of attending physician(s) ______________________

Were you hospitalized? ☐ Yes ☐ No Confined from __/__/__ Through __/__/__
If yes, give name and address of hospital ______________________

First day you were unable to work due to current disability __/__/__

On what date were you able to return to work or do you expect to return to work? __/__/__

Are you entitled to benefits from any of the sources named below, or any other source, because of this disability?

| | | | | | |
|---|---|---|---|---|---|
| Salary Continuance | ☐Yes | ☐No | Social Security Disability | ☐Yes | ☐No |
| Worker's Compensation | ☐Yes | ☐No | Other ______________ | ☐Yes | ☐No |

Benefits provided under your Group Disability Income Plan may be subject to Federal State and local taxation. Contact your Employee Benefits representative or Disability Plan trustee for details on your rights and obligations under the various tax codes. If you wish to have Federal Income Tax withheld from any payments you may receive, indicate below the amount to be withheld and sign the authorization. Withholding requests may also be submitted on IRS Form W-4A.

I request voluntary Income Tax withholding from each disability payment in the amount of $ __________
as authorized under section 3402(0) of the Internal Revenue Code.
Signature of claimant ______________________ Date __/__/__

To all physicians, hospitals, medical service providers, druggists, employers, and all other agencies or organizations. (This includes other insurers, and prepaid health plans.) For claim purposes, I agree that CWA Local 1182 or its representatives may see, or get a copy of, ALL RECORDS* which pertain to ______________________
(Print name of patient)

This form pertains to all of these records: medical, mental and dental care, drug or alcohol use, prescribed drugs, employment and insurance coverage records. This information is for the sole use of CWA Local 1182 or the group contractholder which will process the claim. Unless a law requires it, information will not be given in an identifiable form to any other persons unless I agree to its release in writing. I can revoke this authorization by giving written notice to CWA Local 1182. The notice will not apply to information released before the date CWA Local 1182 has the notice. If not revoked, this form will be valid while the claim is pending but not for more than one year from the date it is signed. I have been given a copy of this form. I agree that a photo copy of this form will be as valid as the original.

Date __________ Signed ______________________ Witness ______________________
How related if signed by other than the patient:

**Local 1182**
Security Benefits Fund
58-38 69th street, 2 Front
Maspeth, New York 11378

CLAIM #

## Attending Physician's Statement of Disability

**Group Insurance**

**"Notice to All Parties Completing this Form: It is fraudulent to fill out this form with information you know to be false or to omit important facts. Criminal and/or civil penalties can result from such acts."**

**You may mail this form directly to:**

**Local 1182**
Security Benefits Fund
58-38 69th street, 2 Front
Maspeth, New York 11378

**Please print**

Name of patient ______________________ Date of birth ____/____/____ (Month / Day / Year)

Patient's address ______________________
No. Street City St Zip

Department | Doctor's Claim number

I hereby authorize release of information requested on this form, by the below named physician for the purpose of claim processing. | Signed (Patient) | Date ____/____/____

**1. History**

(a) When did symptoms first appear or accident happen? ____/____/____

(b) Date patient was first disabled? ____/____/____

(c) Has patient ever had same or similar condition? ☐ Yes ☐ No If Yes, state when and describe ______________________

(d) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

(e) If condition due to automobile accident, indicate state in which it occurred ______________________

(f) Names and addresses of other treating physicians ______________________

**2. Diagnosis**

(a) Diagnosis (including any complications) ______________________

(b) ICD–9–CM Disease Code ________ ________

(c) If disability is due to pregnancy, what is expected/was delivery date? ____/____/____

(d) Please describe any complications that would extend disability longer than for a normal pregnancy ______________________

(e) Subjective symptoms ______________________

(f) Objective findings (including current X–rays, EKGs, laboratory data and any clinical findings) ______________________

**3. Dates of Treatment**

(a) First Visit ____/____/____ (b) Last Visit ____/____/____

(c) Frequency ☐ Weekly ☐ Monthly ☐ Other (specify) ______________________

**4.** Nature of Treatment (including type and date of surgery and medications prescribed, if any) ______________________

**5. Progress**

(a) Has patient ☐ Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed?

(b) Is patient ☐ Ambulatory? ☐ House Confined? ☐ Bed Confined? ☐ Hospital Confined?

(c) Has patient been hospital confined? ☐ Yes ☐ No Confined from ____/____/____ through ____/____/____

If yes, give name and address of hospital ______________________

**6. Cardiac *(If applicable)***

(a) Functional capacity (American Heart Association) ☐ Class 1 (no limitation) ☐ Class 2 (slight limitation) ☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)

(b) Blood pressure (last visit) Systolic ________ Diastolic ________

**7. Physical Impairment (*as defined in Federal Dictionary of Occupational Titles)**

☐ Class 1 — No limitation of functional capacity; capable of heavy work* No restrictions (0-10%)
☐ Class 2 — Medium manual activity* (15-30%)
☐ Class 3 — Slight limitation of functional capacity; capable of light work* (35-55%)
☐ Class 4 — Moderate limitation of functional capacity; capable of clerical/administrative (Sedentary*) activity (60-70%)
☐ Class 5 — Severe limitation of functional capacity; incapable of minimal (Sedentary*) activity (75-100%)
☐ Remarks ______________________________

**8. Mental/Nervous Impairment (if applicable)**

(a) Please define "stress" as it applies to this claimant. ______________________________

(b) What stress and problems in interpersonal relations has claimant had on job? ______________________________

☐ Class 1 — Patient is able to function under stress and engage in interpersonal relations (no limitations)
☐ Class 2 — Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
☐ Class 3 — Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
☐ Class 4 — Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
☐ Class 5 — Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)
☐ Remarks ______________________________

**9.** Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? ☐Yes ☐No

**10. Prognosis**

| | Patient's job | Any other work |
|---|---|---|
| (a) Is patient now totally disabled? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| (b) If not now totally disabled, when was patient able to resume work? | ☐ Full-time ___/___/___ <br> ☐ Part-time ___/___/___ | ☐ Full-time ___/___/___ <br> ☐ Part-time ___/___/___ |

(c) What duties of patient's job is he/she incapable of performing? ______________________________

| | Patient's job | Any other work |
|---|---|---|
| (d) Do you expect a fundamental or marked change in the future? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| (1) If yes, when will patient recover sufficiently to perform duties? | ☐ 1 Mo. ☐ 1 - 3 Mo. <br> ☐ 4 - 6 Mo. ☐ On ___/___/___ | ☐ 1 Mo. ☐ 1 - 3 Mo. <br> ☐ 4 - 6 Mo. ☐ On ___/___/___ |

(2) If no, please explain ______________________________

**11. Rehabilitation**

(a) Is patient a suitable candidate for medical rehabilitation? (i.e. cardiopulmonary program, speech therapy, etc.) ☐ Yes ☐ No

(b) Would job modification enable patient to work with impairment? ☐ Yes ☐ No If yes, explain under remarks.

| | Patient's job | Any other work |
|---|---|---|
| (c) When could trial employment commence? | ☐ Full-time ___/___/___ <br> ☐ Part-time ___/___/___ | ☐ Full-time ___/___/___ <br> ☐ Part-time ___/___/___ |

(d) Would vocational counseling and/or retraining be recommended? ☐ Yes ☐ No

**12. Remarks** ______________________________

Name (attending physician)/Please print ____ Degree/Specialty ____ Telephone # ____

No. ____ Street ____ City ____ St ____ Zip ____

Signature ____ Date ___/___/___