

RETURN FORM TO:

BENEFIT CONSULTANTS, INC.
13515 BARRETT PARKWAY DR., STE 265
BALLWIN, MO 63021-5870
PHONE (314) 822-7890 FAX (314) 822-0992

ST. LOUIS GRAPHIC ARTS JOINT HEALTH AND WELFARE FUND DISABILITY CLAIM FORM

PART 1: MUST BE COMPLETED BY PARTICIPANT

PARTICIPANT NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	HOME PHONE #
HOME ADDRESS	CITY	STATE	ZIP CODE
NAME OF EMPLOYER	EMPLOYER PHONE #	JOB TITLE	

WAS THIS DISABILITY WORK RELATED? YES NO IF YES, HAVE YOU FILED WITH YOUR EMPLOYER? YES NO

I WAS FIRST TREATED BY DR. _____ ON _____
DOCTOR NAME DATE OF VISIT

THE DATE OF MY LAST DOCTOR VISIT WAS ON _____ WITH DR. _____

CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION:
 I hereby certify that the above information is true and correct to the best of my knowledge. I understand that a falsification or withholding of material facts may result in loss of benefits. For the purpose of determining eligibility for benefits and claim processing, I hereby authorize St. Louis Graphic Arts Joint Health & Welfare Fund to receive from and/ or provide to medical practitioners, medically related facilities, insurance companies or like organizations or my employers, information as to physical or mental condition of myself or my covered dependents. I know that I have a right to receive a copy of this authorization. I agree a photographic copy is as valid as the original.

X _____ x _____
PARTICIPANT SIGNATURE DATE

PART 2: TO BE COMPLETED BY PHYSICIAN

PATIENT'S NAME	DATE OF FIRST VISIT FOR CURRENT CONDITION
DIAGNOSIS AND CONCURRENT CONDITIONS	

Is sickness or accident related to patient's employment? YES NO If yes, Please Explain _____

Date patient first consulted you for this condition? _____ Expected date of delivery? _____

Was surgery performed? YES NO If yes, give date and type of surgery done _____

Considering the claimant's occupation, could claimant resume duties of his usual and customary work while continuing treatment? YES NO
 If no, please explain why _____

Is patient still under your care? YES NO Last Visit _____ Next Appointment _____

Patient was continuously disabled (unable to work) from _____ to _____

If off longer than the normal length of disability for this condition please list complications _____

The patient recovered, or will recover, sufficiently to return to his regular job on _____

Dates of hospitalization from _____ to _____ Hospital Name _____

ATTENDING PHYSICIAN'S PRINTED NAME	TAX IDENTIFICATION NUMBER	
STREET ADDRESS	() _____ PHONE NUMBER	() _____ FAX NUMBER
CITY STATE ZIP	ATTENDING PHYSICIAN SIGNATURE	

PART 3: TO BE COMPLETED BY FUND OFFICE ONLY

Weekly Salary _____ Last Day Worked _____ Returned to Work _____ Hrs in Work Week _____

Whom Contacted _____ Date _____ Signed: _____

NOTES: _____
