RETURN FORM TO: J.W. Terrill | a Marsh & McLennan Agency LLC company
825 Maryville Centre Drive, Suite 200
Chesterfield, MO 63017
FAX: 866-731-9962
EMAIL: jwtclaims@jwterrill.com

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

PART 1: TO BE COMPLETED BY THE EMPLOYEE

NAME OF EMPLOYEE (Last Name) (First Name) (Middle Initial)			
ADDRESS (Street)	(City)	(State)	(Zip Code)
SOCIAL SECURITY NUMBER (SSN)	BIRTHDATE	SEX ☐ M ☐ F	
HOME PHONE # ( )		CELL PHONE # ( )	
EMAIL ADDRESS		JOB TITLE	
NAME OF EMPLOYER	EMPLOYER PHONE # ( )		

PLEASE TYPE OR PRINT. BE SURE TO ANSWER ALL QUESTIONS – FAILURE TO DO SO MAY DELAY YOUR CLAIM. USE SEPARATE PIECE OF PAPER TO COMPLETE ANSWERS IF NECESSARY.

DATE OF ACCIDENT/INJURY OR BEGINNING DATE OF ILLNESS:	DATE FIRST UNABLE TO WORK
IF DISABILITY IS DUE TO ACCIDENT/INJURY, PROVIDE WHERE THE INJURY OCCURRED AND HOW THE INJURY OCCURRED:	
IS DISABILITY WORK RELATED? ☐ YES ☐ NO IF YES, HAVE YOU FILED WITH YOUR EMPLOYER? ☐ YES ☐ NO	
NAME OF TREATING PHYSICIAN:	PHONE # ( )

CLAIMANT'S CERTIFICATION

THIS IS TO CERTIFY THAT THE FACTS AS INDICATED ABOVE ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF

SIGNATURE OF EMPLOYEE	DATE

AUTHORIZATION TO RELEASE INFORMATION

I certify that the information shown above is correct to the best of my knowledge and belief. I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to J.W. Terrill Benefit Administrators, the Plan Administrator or their employees and authorized agents for the purpose of validating and determining benefits payable. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request.

This authorization, or a photo static copy of the original, shall be valid from the date signed for the duration of the claim.

My authorized representative or I may revoke this authorization at any time as it applies to further disclosures by writing the Insurance Company, Prompt notice of revocation will then be give to all persons to who the Insurance Company has disclosed protected health information in reliance to the original authorization as required by law. A valid authorization or court order for information does not waive other privacy rights.

SIGNATURE OF EMPLOYEE	DATE