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

TO BE COMPLETED BY THE EMPLOYER			
NAME OF EMPLOYEE (Last Name) (First Name) (Middle Initial)			
ADDRESS (Street) (City) (State) (Zip Code)			
SOCIAL SECURITY NUMBER (SSN)	BIRTHDATE	SEX ☐M ☐F	
OCCUPATION:			
WEEKLY SALARY/HOURLY WAGE:	LAST DATE WORKED:	RETURNED TO WORK DATE:	HOURS IN WORK WEEK:
HAS THE EMPLOYEE BEEN PAID ANY WAGES INCLUDING, BUT NOT LIMITED TO, VACATION/PTO TIME BETWEEN LAST DAY WORKED AND RETURNED TO WORK DATE? IF YES, PROVIDE DATES, HOURS WORKED, AND TYPES OF WAGES.			
NAME OF EMPLOYER:	EMPLOYER PHONE #:	EMPLOYER FAX #:	
HUMAN RESOURCE MANAGER:			
HUMAN RESOURCE MANAGER EMAIL ADDRESS:			
THIS IS TO CERTIFY THAT THE FACTS AS INDICATED ABOVE ARE TRUE TO THE BEST OF MY KNOWLEDGE SIGNATURE OF AUTHORIZED REPRESENTATIVE		DATE:	