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www.ufcwtrust.com

CLAIM STATEMENT – DISMEMBERMENT OR LOSS OF SIGHT

NAME OF MEMBER: _____
(LAST) (FIRST) (MIDDLE) SSN OR ID#

NAME OF PATIENT: _____
(LAST) (FIRST) RELATIONSHIP TO EMPLOYEE DATE OF BIRTH

DATE OF ACCIDENT OR ILLNESS: _____
(MM/DD/YYYY)

IF ACCIDENT, PLACE OF ACCIDENT: _____
(CITY) (STATE)

DESCRIBE FULLY HOW THE ACCIDENT OCCURRED, THE NATURE OF INJURIES RECEIVED AND LOSS(ES) FOR WHICH CLAIM IS MADE:

DID THE LOSS OCCUR IN CONNECTION WITH YOUR EMPLOYMENT? YES NO

DATE OF SURGICAL PROCEDURE: _____
(MM/DD/YYYY)

NAME AND ADDRESS OF ATTENDING PHYSICIAN(S)

NAME: _____
(LAST) (FIRST) (MIDDLE) PHONE NUMBER

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP CODE)

NAME: _____
(LAST) (FIRST) (MIDDLE) PHONE NUMBER

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP CODE)

MEMBER SIGNATURE: _____ DATE: _____
(MM/DD/YYYY)

Please Read: No benefits will be paid if the claim is received by the Trust Fund Office more than one year after the date of the loss.

(SEE REVERSE SIDE FOR PHYSICIAN'S STATEMENT)

ATTENDING PHYSICIAN'S STATEMENT

NAME OF PATIENT: _____
(LAST) (FIRST) DATE OF BIRTH

1. NATURE OF LOSS (IF AMPUTATION, SEE NOTE BELOW): _____

2. IF LOSS OF SIGHT INVOLVED, IN YOUR OPINION IS LOSS OF SIGHT COMPLETE AND IRRECOVERABLE? YES NO
IF YES, PLEASE GIVE DATE WHICH SUCH LOSS BECAME COMPLETE AND IRRECOVERABLE: _____
(MM/DD/YYYY)

3. IN YOUR OPINION WAS LOSS DUE TO ACCIDENT? YES NO IF YES, GIVE DETAILS: _____

4. IF INJURY OR DISEASE REQUIRED SURGICAL OPERATION, GIVE A DESCRIPTION OF OPERATION AND DATE PERFORMED:

5. IN YOUR OPINION WAS ANY DISEASE AN UNDERLYING CAUSE IN THIS LOSS? YES NO
IF YES, PLEASE EXPLAIN: _____

6. WAS PATIENT CONFINED TO HOSPITAL AS A RESULT OF LOSS? YES NO
(A) IF YES – NAME OF HOSPITAL: _____
(B) AS IN-PATIENT AS OUT-PATIENT

ATTENDING PHYSICIAN'S NAME: _____
(LAST) (FIRST) (MIDDLE)

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP CODE)

ATTENDING PHYSICIAN'S SIGNATURE: _____ PHONE NUMBER

DATE: _____
(MM/DD/YYYY)

NOTE: IF AMPUTATION, PLEASE INDICATE ON
DIAGRAM SHOWING SITE(S) OF AMPUTATION

