

# BAC Local Union 15 Welfare Fund

## DISABILITY CLAIM - SUPPLEMENTARY

This form MUST be completed on or about: \_\_\_\_\_

### PART A: TO BE COMPLETED BY PATIENT (INSURED)

#### 1. Personal Information:

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

#### 2. Authorization to release information:

I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment. I also make claim for benefits and certify that the statements under Part A are true and complete to the best of my knowledge.

Signature of Insured: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

3. State last day worked because of disability: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

4. On what date were or will you be able to perform full-time work: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

5. If injured, how and where did the accident occur? \_\_\_\_\_

6. Did injury occur in the course of employment?  Yes  No

7. Was this due to a motor vehicle accident?  Yes  No

8. Have you or do you intend to file this claim under Workmen's Compensation?  Yes  No

9. Are you now engaged in the duties of any occupation or endeavor for wages, profits or compensation?  Yes  No

### PART B: ATTENDING PHYSICIAN'S STATEMENT

10. Diagnosis and concurrent conditions: \_\_\_\_\_

11. Frequency of visits:  Weekly  Monthly  Other: \_\_\_\_\_

12. Is patient totally disabled from any occupation?  Yes  No

Date patient became totally disabled: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

13. Is patient totally disabled from his/her regular occupation?  Yes  No

Date patient became totally disabled: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

14. On what date will the patient be able to resume normal activities and return to work? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

#### 15. Attending Physician's Information:

Physician's Name: \_\_\_\_\_ Physician's Signature: \_\_\_\_\_

Degree: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

#### 16. Remarks:

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Return completed forms to:

BAC Local Union 15 Welfare Fund  
Attn: Claims Department  
3100 Broadway, Suite 805  
Kansas City, MO 64111  
(816)777-2668 | Fax (816)756-3659