



IUOE Local 132 Health and Welfare Fund

P.O. Box 2626 Huntington, West Virginia 25726-2626
(304) 525-0482 1-800-642-3525 www.iuoe132.org

SUPPLEMENTAL DISABILITY CLAIM FORM

This form must be completed by the Participant AND the attending Physician. Be sure ALL questions are answered. Unanswered Questions may delay benefit consideration until the information is received.

Participant Information

Name: _____ ID Number or SSN: _____
Address: _____ Home Phone: _____
_____ Name of Employer: _____

Participant's Statement

Is condition due to an accident or injury? Yes No If yes, date of accident or injury _____
Did accident or injury happen while at work? Yes No If yes, briefly explain _____
Are you unable to work because of disability? Yes No _____
If not disabled, when did you return to work? ____ / ____ / ____ _____

I understand the Supplemental Disability Benefit is provided for eligible participants only and is subject to FICA and Medicare taxes. I understand I will receive a W-2 tax form for any benefits paid to me.

I hereby declare the information I have provided is true and correct. I understand that a false statement may disqualify me from benefits and that the Fund has the right to recovery from any Participant, any payments made as a result of misrepresentation, mistake or error, irrespective of the party causing such mistake or error.

I authorize release to or by the IUOE Local 132 Health and Welfare Fund of any medical or insurance information required to process any claims submitted on my behalf. A photocopy of this document may be honored.

→ _____
Participant's Signature

→ _____
Date Signed

Attending Physician's Statement

Physician: _____ Patient's Name: _____
Address: _____ Date of First Treatment: _____
_____ Date of most recent Treatment: _____
Phone: _____ Frequency of Treatments: _____

This patient has been continuously disabled (unable to work) from _____ through _____

When should the patient be able to return to work? _____

Nature of illness or injury (Describe complications, if any): _____

→ _____
Physician's Signature

→ _____
Date Signed