125 Barclay Street
New York, N.Y. 10007-2179
Telephone: (212) 815-1234

Health & DC37 Security Plan

Dear Member:

Disability claim forms received by our office are frequently delayed or returned to the member because they are incomplete. Your Claim May Be Delayed Or Returned Unless You Do The Following:

- Sign your claim.
- Give the phone number of your timekeeper/payroll/personnel department.
- Describe your illness.
- If you were involved in an accident, indicate how, when and where you were injured.
- Make certain your Social Security number/and or PID# is correct.
- Enclose a copy of your Marriage/Divorce/Separation papers if you have changed your name.
- Attach an explanation to your claim if it is filed 15 or more days after onset of your disability.
- Make sure you have a DC37 Health & Security Plan Enrollment Card on file.

The "Physician's Statement" section of the claim form is to be entirely completed and only by a licensed medical doctor.

You should not complete or alter any of the information in this section. Check particularly to be sure that your doctor includes dates of all treatments and expected duration of your disability.

If you leave your claim form with your physician, have him/her return the claim to you. This is recommended so you can review the form to ensure that it is completed properly before submitting it to the Plan office for processing.

If you have any questions, please call the above number.

Yours truly,

Eric Reid
Unit Manager
Disability Unit

ER:no

DISTRICT COUNCIL 37 HEALTH & SECURITY PLAN

125 BARCLAY STREET, NEW YORK, N.Y. 10007

HS:DIS 013

Please Type or Print

SHORT-TERM DISABILITY BENEFIT CLAIM

Phone: (212) 815-1234

TO BE FULLY COMPLETED BY EMPLOYEE AND FILED WITHIN 15 DAYS FROM THE DAY YOU BECOME DISABLED REGARDLESS OF SICK, VACATION OR ANNUAL TIME.

EMPLOYEE INFORMATION

Name _____ Soc. Sec. No./PID _____

Home Address _____
No. & Street City State Zip

Date of Birth _____ Male☐ Female☐ Home Phone _____

JOB INFORMATION

Name of your work place _____ Date of Employment _____

Work Address _____ Timekeeper Personnel Phone No. _____

Department _____ Payroll

Job Title _____ If school worker, District Office No. _____

Annual Salary _____ Hours worked per day _____

How many sick days did you have on the date you be became disabled? _____

ILLNESS INFORMATION

When did you become totally disabled so that you could not work? Date: _____

What date did you first see a doctor? _____ Name of doctor _____

Describe your illness _____

Have you returned to work yet? Yes☐ No☐ If yes, what date? _____

Have you ever received disability payments for the same illness? Yes☐ No☐ If yes, what year? _____

IF CONFINED IN HOSPITAL

Name of Hospital _____

Address of Hospital _____

Date Admitted _____ ☐AM ☐PM Date Discharged _____

IF DISABILITY IS DUE TO ACCIDENT

A. Date of accident _____ ☐AM ☐PM B. How did it happen? _____

C. Did it happen at work? Yes☐ No☐ D. Did you file for Workers' Compensation? Yes☐ No☐

E. Is there a lawsuit? Yes☐ No☐

F. If yes, give attorney's name _____
Address _____ Phone No. _____

SIGN HERE

The above statements are true and complete to the best of my knowledge and belief and I hereby authorize any hospital or physician who has treated me to furnish any and all medical information to District Council 37 Health & Security Plan.

Signature _____ Date _____

(SIGNATURE ONLY – DO NOT PRINT)

IF YOU ARE PLANNING TO GO OUT OF THE NEW YORK AREA AFTER YOU HAVE APPLIED FOR DISABILITY BENEFITS, YOU MUST CONTACT THE HEALTH & SECURITY PLAN OFFICE OR YOUR CLAIM WILL BE DECLARED INELIGIBLE.

DISTRICT COUNCIL 37 HEALTH & SECURITY PLAN

125 BARCLAY STREET, NEW YORK, N.Y. 10007

(212) 815-1234

ATTENDING PHYSICIAN'S STATEMENT

Patient: _____ **Claim No.** _____ **Age:** _____ **Sex:** _____

DIAGNOSTIC CATEGORY

A. Medical Conditions/Diagnosis

(IMPORTANT: **THIS CLAIM CANNOT BE PROCESSED WITHOUT THE APPROPRIATE ICD CODES.)**

	ICD CODE	DESCRIPTION
Primary Diagnosis	____ . ____	_____
Secondary Diagnosis	____ . ____	_____
	____ . ____	_____

Is patient's disability related to Substance Abuse YES☐ NO☐ and/or Alcoholism YES☐ NO☐
Is patient's disability related to an accident? YES☐ NO☐
Is patient's disability a result of an injury arising out of and in the course of employment or an occupational disease? YES☐ NO☐

TREATMENT INFORMATION

B. Specific Dates of Treatment for this illness: _____ ; _____ ; _____ ; _____ ; _____

If hospitalized for this disability: Date Admitted _____ Date Discharged _____
Name of Hospital: _____ Address: _____
If surgery was performed, give the date(s): _____
Type of Surgery: *(with CPT code)* _____
If pregnancy, list date, or expected Date of Delivery: _____
Type of delivery: Normal☐ C-Section☐

C. Therapy

Is patient receiving Chemotherapy, Radiation or on Dialysis? YES☐ NO☐
If yes, give dates: _____ ; _____ ; _____ ; _____ ; _____ ; _____ ; _____ ; _____
Is patient receiving Physical Therapy? YES☐ NO☐
If yes, give dates: _____ ; _____ ; _____ ; _____ ; _____ ; _____ ; _____ ; _____
Is patient in a program for Substance Abuse? YES☐ NO☐
Name of Program _____ Telephone Number _____
Dates in attendance: _____ ; _____ ; _____ ; _____ ; _____ ; _____ ; _____

D. Anticipated Duration For This Disability

(Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)
Patient's disability is expected to extend from _____ through _____

SIGN HERE

_____ Physician's Signature	_____ Name (Print)	_____ Degree Specification
_____ Licensed in the State of	_____ License Number	
_____ Address	_____ Phone	_____ Date