UA Local 190 Plumbers/Pipe Fitters/Service Technicians/Gas Distribution
Health Care Plan
Loss of Time Benefit

Employee Information

Employee Social Security #	Last Name	First Name
Phone #	Address	City/State/Zip
E-Mail Address		

1. Is your disability work related? ☐ Yes ☐ No

2. Have you filed a Workers' Compensation Claim? ☐ Yes ☐ No

3. Do you intend to file? ☐ Yes ☐ No

4. Last Active Day at Work:

5. Date you became unable to work at your occupation because of your disability:

6. Date you returned or expect to return to work:

7. Have you had a previous disability claim? ☐ Yes ☐ No

8. ☐ Accident: When and where did it happen?

☐ Illness: When did you first notice and what is the nature of your disability?

9. How does your disability prevent you from working?

Certification

I certify the above answers are true and complete to the best of my knowledge and belief.
Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties.

Employee Signature *(Required)*	Date

Additional Information:

Physician Report

1. Diagnosis

A. Diagnosis :	ICDA Classification
B. Symptoms:	C. How does this condition interfere with patient's ability to work?

2. **Pregnancy** (*if applicable*)

A. Expected Date of Delivery	B. Actual Date of Delivery:	C. Type of Delivery ☐ Vaginal ☐ C– Section
D. Significant Complications, if any:		

3. **History**

A. Date you recommended the patient stop work:	B. When did symptoms appear or accident happen?
C. Has the patient ever had a similar condition? If yes, when? _____ ☐ Yes ☐ No	
D. Is this condition related to the patient's employment? ☐ Yes ☐ No	E. Did you complete a workers' compensation form? ☐ Yes ☐ No

4. **Treatment**

A. Date of First Visit:	B. Date(s) of subsequent visits:	C. Date of most recent visit:
D. Planned course and duration of treatment (*include surgery and medications, if any*):		

5. **Hospitalization** (*if applicable*)

A. Date Admitted:	B. Date Discharged:	C. Reason
D. Name of Hospital:		

6. **Prognosis**

A. Since the onset of symptoms, the patient's conditions has: ☐ Improved ☐ Not Changed ☐ Retrogressed

B. When do you anticipate the patient can return to work? ☐ Date: _____ ☐ Follow up in _____ weeks ☐ Never

7. **Physician Information** (*Please type or p*rint)

Name of Physician completing this form:		Phone Number: ( )
Specialty:	Tax ID. #:	Fax Number: ( )
Mailing Address:	City/ State/ Zip:	

Signature: _____ Date: _____