

(FOLD AND MOISTEN GLUE - PLEASE DO NOT STAPLE)

WEEKLY DISABILITY BENEFITS

SOUTHERN CALIFORNIA PIPE TRADES TRUST FUND
501 SHATTO PLACE, FIFTH FLOOR
LOS ANGELES, CA 90020
(213) 385-6161

FORMS WILL BE RETURNED IF THE BELOW INFORMATION IS INCOMPLETE

PART 1 EMPLOYEE'S STATEMENT

EMPLOYEE'S NAME _____ SOC. SEC. NO. _____
(please print)

ADDRESS _____ DATE OF BIRTH _____
(No.) (Street) (City) (State) (Zip)

FIRST FULL DAY UNABLE TO WORK _____ DATE RETURNED TO WORK _____

IS YOUR EMPLOYER CONTINUING YOUR PAY WHILE DISABLED: YES NO

IS DISABILITY DUE TO YOUR OCCUPATION? _____ EMPLOYED BY _____

ARE YOU FILING A CLAIM FOR WORKMEN'S COMPENSATION? _____

HAVE YOU FILED A CLAIM FOR STATE DISABILITY? _____

IS THIS CONDITION DUE TO AN ACCIDENT? YES NO

IF YES, WHEN? _____ 19 _____ A.M. _____ P.M. _____ WHERE? _____
(Date) (Time)

HOW? _____

I hereby claim benefits and certify that for the period covered by this claim I was unemployed and disabled, that the foregoing statements are to the best of my knowledge and belief true, correct and complete. I hereby further authorize my attending physician to furnish and disclose all facts concerning my physical condition.

DATE SIGNED _____ EMPLOYEE'S SIGNATURE _____

LOCAL NO. _____ HOME PHONE NO. _____

LAST EMPLOYER: _____ LAST DATE WORKED: _____

PART 2 ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME _____

NATURE OF SICKNESS OR INJURY (Describe complications, if any) _____

DATE OF FIRST TREATMENT FOR THIS DISABILITY _____

DATE OF MOST RECENT TREATMENT _____

FREQUENCY OF TREATMENTS _____

THE PATIENT HAS BEEN CONTINUOUSLY DISABLED (UNABLE TO WORK) FROM _____ THRU _____
(Approximate)

IF STILL DISABLED, WHEN SHOULD PATIENT BE ABLE TO RETURN TO WORK? _____
(Approximate)

REMARKS _____

DATE _____ (print or type doctor's name)

For Fund Office Use Only

JAN.	FEB.	MAR.	APR.	MAY	JUNE
JULY	AUG.	SEPT.	OCT.	NOV.	DEC.

SIGNED _____

ADDRESS _____

CITY _____

PHONE _____

FOLD

FOLD

To: SOUTHERN CALIFORNIA PIPE TRADES TRUST FUND
501 SHATTO PLACE, FIFTH FLOOR
LOS ANGELES, CA 90020



FROM

AFFIX
STAMP

OPEN
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