MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND
1400 DISTRICT AVENUE • PO BOX 1501
BURLINGTON, MASSACHUSETTS 01803-1501
TELEPHONE (781) 272-1000 • TOLL FREE (800) 342-3792 • FAX (781) 238-0703

SHORT TERM DISABILITY CLAIM FORM

Section 2 – to be completed by Physician

Patient Information:

Member Name _____ Social Security No. _____

Member Address _____

Date of Birth _____ Patient Gender ____ MALE ____ FEMALE

Diagnosis, Treatment and History Information:

Primary Diagnosis for Disability and ICD code: _____

Additional Diagnoses: _____

Is the condition due to an accident or sickness arising out of the patient's employment? YES NO

Date you were first consulted for this condition: _____

Date symptoms first appeared or injury occurred: _____

Date Patient became totally disabled and unable to work: _____

Estimated return to work date: _____

Date of next appointment: _____

Surgery/Hospitalization Dates: _____ Primary Procedure: _____

Attending Physician Information:

Physician Name: _____ Specialty: _____

Physician Address: _____

Phone Number: _____ Fax Number: _____

Tax Identification Number: _____ NPI Number: _____

Physician's Signature: _____ Date: _____

A faxed copy of this form will only be accepted if faxed directly from physician's office

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND
1400 DISTRICT AVENUE • PO BOX 1501
BURLINGTON, MASSACHUSETTS 01803-1501
TELEPHONE (781) 272-1000 • TOLL FREE (800) 342-3792 • FAX (781) 238-0703

SHORT TERM DISABILITY CLAIM FORM

Section 1 – To be Completed by Plan Participant

Member Information:

Member Name _____ Social Security No. _____

Member Address _____

Date of Birth _____ Phone Number _____

Disability Information:

Nature of Disability: _____

Please check one: Injury ○ Illness ○ Date Illness began or Injury/Accident occurred: _____

If Injury/Accident, describe HOW, WHEN and WHERE the injury occurred: _____

_____

_____

Did Injury/Accident occur at work? YES ○ NO ○
If yes, claim must be submitted to your employer's Workers' Compensation carrier

Is Injury/Accident related to a Motor Vehicle Accident? YES ○ NO ○
If yes, claim must be submitted to your Motor Vehicle Insurance carrier

Employment Information:

Date you last worked: _____

Employer Name: _____ Employer Phone Number: _____

Employer Address: _____

Are you collecting: Unemployment Benefits? YES ○ NO ○
Any other form of compensation (i.e. sick, vacation pay)? YES ○ NO ○
(If yes to either question, you are NOT eligible for Accident & Sickness Benefits)

I certify that the above information is correct to the best of my knowledge; any false statement could result in a loss of benefits.

Member Signature: _____ Date: _____

A faxed copy of this form will only be accepted if faxed directly from physician's office