This is a Writable Form

DISTRICT COUNCIL 37 HEALTH & SECURITY PLAN

55 WATER STREET, NEW YORK, NY 10041

HS:DIS 013

Phone: (212) 815-1390

SHORT-TERM DISABILITY BENEFIT CLAIM

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 ______

Department ______

Timekeeper
Personnel Phone No. ______
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

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

55 WATER STREET, NEW YORK, NY 10041

(212) 815-1390

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

DC37 Health & Security Plan
55 Water St., New York, NY 10041 | 212.815.1390

Follow the instructions below so your claim may be processed as quickly as possible.

Dear Member:

Disability claim forms received by our office are frequently delayed or returned to the member because they are incomplete. Your claim will be delayed or returned unless you do the following:

- Sign your claim. (electronic signatures are acceptable)
- Include 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.
- If you have changed your name, enclose a copy of your marriage/divorce/separation papers.

Page 2 of the claim form is to be **entirely completed only** by a licensed medical doctor. You should not complete or alter any of the information in this section. Check to be sure that your doctor has filled out all information in each section (Parts A-D) and signs the form.

You or your physician may fax your completed Short-Term Disability Benefit Claim form and supporting documents to 212.298.9886. If you do not have access to a fax machine, you may email your documents to disabilityunit@dc37.net.

If you have any questions, please call 212.815.1390.

Very truly yours,

Lisa Reneo

Lisa Reneo
Unit Manager
Disability Unit

209 x23