PENSION TRUST FUND • WELFARE FUND • RETIREE WELFARE PLAN
VACATION SAVINGS PLAN • RETIREMENT ENHANCEMENT FUND

6150 JOLIET ROAD, COUNTRYSIDE, IL 60525-3994
PHONE: (708) 482-7300 FAX: (708) 482-3056

JAMES M. SWEENEY, CHAIRMAN / DAVID M. SNELTEN, SECRETARY-TREASURER

ACCIDENTAL DISMEMBERMENT BENEFIT CLAIM FORM

Member Name: ______________________________ Medical ID#: ________________

Address: ______________________________ Date of Birth: ________________

- Date injury occurred: ______________________________
- Describe what happened: ______________________________

  ____
- What injuries occurred? ______________________________

  ____
- Complete address of where injury occurred: ______________________________

  ____
- Is this injury related to a Workers Compensation Claim or Automobile Accident Claim? _____YES_____NO
- Full name and complete address of surgeon who treated injury: ______________________________

  ____

The Fund office will be requesting additional information from your treating physician to verify the nature of your injuries. This may include physician's notes, operative reports and x-rays if necessary. Please be advised all claims for benefits must be received by the Fund office within one year from the date of service, so please make sure any information requested from your physician/surgeon is received as soon as possible.

I hereby certify the above statements are true and complete to the best of my knowledge and belief. I authorize the release when requested by the Health and Welfare Fund, of any facts concerning the injury, illness and treatment of myself for this benefit. A photocopy of this authorization shall be considered as effective and valid as the original.

No assignment will be accepted. All payments will be made to the member at the address on file at the Fund office.

______________________________ ________________
Member Signature Date

updated November 2018

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