NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

COMMUNICATION WORKERS OF AMERICA LOCAL 1170

MAIL TO: CWA Local 1170
4061 W Henrietta Rd
Rochester NY 14623
Fax: 585-632-1792

PART A – CLAIMANT'S STATEMENT (Please Print or Type) ANSWER ALL QUESTIONS

1. My name is _____ First _____ Middle _____ Last _____ Social Security Number

2. Address _____ Number _____ Street _____ City _____ State _____ Zip Code _____ Apt. No.

3. Tel. No. _____ 4. My age is _____ 5. Married (Check one) ☐ Yes ☐ No

6. My disability is (if injury, also state how, when, and where it occurred) _____

7. I became disabled on _____ Month _____ Day _____ Year a. I worked on that day ☐ Yes ☐ No

b. I have since worked for wages or profit. ☐ Yes ☐ No If "Yes", give dates _____

8. Give name of last employer. If more than one employer in the last eight (8) weeks, name all employers.

EMPLOYER'S			DATES OF EMPLOYMENT		AVERAGE WEEKLY WAGES (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	FROM Mo. Day Yr.	THROUGH Mo. Day Yr.	

9. My job is or was _____ Occupation _____ Name of Union and Local Number, if Member

10. For the period of disability covered by this claim
   a. Are you receiving wages, salary or separation pay: _____ ☐ Yes ☐ No
   b. Are you receiving or claiming:
      (1) Workers' compensation for work-connected disability _____ ☐ Yes ☐ No
      (2) Unemployment Insurance Benefits _____ ☐ Yes ☐ No
      (3) Damages for personal injury _____ ☐ Yes ☐ No
      (4) Benefits under the Federal Social Security Act for long-term disability _____ ☐ Yes ☐ No

   IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 10a OR 10b, COMPLETE THE FOLLOWING:
   I have ☐ received ☐ claimed from _____ for the period _____ Date to _____ Date

11. I have received disability benefits for another period or periods of disability within the 52 weeks immediately before my present disability began _____ ☐ Yes ☐ No

12. I have read the instructions above. I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled; and that the foregoing statements, including any accompanying statements, are to the best of my knowledge true and complete.

SIGN HERE ➔ Claim signed on _____ Date _____ Claimant's Signature

To any medical provider, medical care facility, insurer, government-sponsored health plan or employer; I permit (while my claim is pending) the release of any medical information about me to the Company and its representatives. The Company's representatives include Health Economics Group, Inc., reinsuring companies and other persons or groups performing business or legal services relating to my claim. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I have or have had in the past. The Company will use this information to find out if my claim is eligible. A copy of this authorization (one of which will be given to me by the Company upon my request) will be as valid as this one. I certify that the above information given by me in support of this claim is true and correct.

Patient's or Authorized Representative's Signature _____ Date _____

If authorized Representative, Relationship to Patient _____

or Legal Designation _____ Number _____ Street _____ City _____ State _____ ZIP Code

➔ **DOCTOR MUST COMPLETE PART B ON REVERSE SIDE** ⬅

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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PART B – HEALTH CARE PROVIDER'S STATEMENT (Please print or type)

The Health Care Provider's statement must be filled in completely. For Item 7-d, give approximate date. Make some estimate. Delay in the payment of Disability Benefits may be prevented. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date under "Remarks." If claiming supplemental accident benefits, attach itemized bills.

1. Claimant's Name _____ (First / Middle / Last) 2. Age _____ 3. ☐ Male ☐ Female

4. Diagnosis/Analysis: _____

   a. Claimant's Symptoms: _____

   b. Objective Findings: _____

5. Claimant Hospitalized? ☐ Yes ☐ No From _____ To _____

6. Operation Indicated? ☐ Yes ☐ No a. Type _____ b. Date _____

7. Enter Dates for the Following:

	Month	Day	Year
a. Date of your first treatment for this disability			
b. Date of your most recent treatment for this disability			
c. Date Claimant was unable to work because of this disability			
d. Date Claimant will be able to perform usual work			

8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease? ☐ Yes ☐ No

9. Has Claimant ever had same or similar condition? ☐ Yes ☐ No If yes, state when and describe _____

10. Remarks (Attach additional sheet, if necessary): _____

I affirm that I am a:	Licensed in the State of	License Number
☐ Chiropractor ☐ Physician ☐ Psychologist ☐ Dentist ☐ Podiatrist ☐ Nurse-Midwife		

Health Care Provider's Signature _____ Date

Health Care Provider's Name (Please Print) _____ Phone Number _____

Office Address _____ (Number / Street / City / State / ZIP Code)

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