BAKERS UNION & FELRA
HEALTH AND WELFARE FUND

P.O. BOX 1064, SPARKS, MD 21152-1064

(866) 662-2537

WEEKLY ACCIDENT AND SICKNESS BENEFITS CLAIM FORM

Fill out your section of the claim (PARTICIPANT'S STATEMENT) before forwarding to your physician. Instructions are on reverse side.

PARTICIPANT'S STATEMENT

2. Member's Social Security No.

1. My Name is ______________________________ ______ - ______ - ______
(PLEASE PRINT) FIRST MIDDLE LAST

3. Address ______________________________ 4. Age ______
NUMBER STREET CITY OR TOWN STATE ZIP CODE

5. My disability is (If injury, also state how, when and where it occurred) ______________________________

____

6. I became disabled on ____/____/______
MM / DD / YEAR

Date Last Worked ____/____/______
MM / DD / YEAR

Was more than $^{1}/_{2}$ day completed? Yes ☐ No ☐

7. Most recent employer ______________________________ Local Union ______________

8. Are you now receiving Workers' Compensation Benefits? Yes ☐ No ☐
If the answer is "yes," please indicate dates that you started receiving these benefits. ______________

9. I authorize the release of any medical information necessary to process this claim.

Claim signed on ______________________ ______________________
DATE MEMBER'S SIGNATURE

DOCTOR'S STATEMENT

1. Patient's Name ______________________________ 2. Male ☐ Female ☐
FIRST MIDDLE LAST

3. Diagnosis ______________________________

4. Is surgery indicated? Yes ☐ No ☐ a. Type ______________ b. Date ______________

5. Enter Dates for the Following:

a. Date patient was unable to work because of this disability: ______________

b. Date patient was first seen for treatment for this disability: ______________

c. Date of your most recent treatment for this disability: ______________

d. Date patient will be able to return to work: (subject to revision) ______________

e. Maternity: Expected date of delivery: ______________

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

Remarks: ______________________________

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______________________ ______________________ ______________________
(**PLEASE PRINT**) PHYSICIAN'S NAME PHYSICIAN'S SIGNATURE PHYSICIAN'S PHONE NUMBER

Address ______________________________
NUMBER STREET CITY OR TOWN STATE ZIP CODE

READ THESE INSTRUCTIONS CAREFULLY BEFORE YOU COMPLETE YOUR CLAIM FOR THE DISABILITY BENEFITS. FILE YOUR CLAIM PROMPTLY.

1. Use this form only if you become sick or disabled while eligible for benefits.
2. You must complete all items in the "Participant's Statement" and mail or take the entire form to your physician as soon as possible. Be accurate in completing the form; check all dates.
3. Be sure to date and sign your claim. If you cannot sign this claim form, your representative may sign on your behalf. In that event, the representative's relationship to you and his/her address should be noted under his/her signature.
4. Do not mail this claim unless your doctor has completed and signed the "Doctor's Statement." If possible, have it completed while you are in the doctor's office.
5. Your benefits will begin as soon as a complete and accurate statement is received by the Fund Office.
6. Disability benefits are not payable for any disability caused by willful intention to bring about an injury or sickness or resulting from an injury or sickness sustained in the commission of an illegal act.
7. Disability benefits are not payable for any period during which you:
   A. Become sick or disabled prior to the time you are eligible.
   B. Receive, or are eligible to receive, unemployment insurance benefits from any state.
   C. Receive, or are entitled to receive, benefits under any Workers' Compensation legislation or similar legislation.