WEEKLY ACCIDENT & SICKNESS CLAIM FORM

Warehouse Employees Union Local No. 730 Health and Welfare Trust Fund
P.O. Box 1064, Sparks, MD 21152-1064
(800) 730-2241 Toll Free

Instructions:
(1) Complete Section I and either Section II (work related) or Section III (not work related)
(2) Have your physician complete Section IV and submit completed form to the Fund Office.
(3) If injury is work-related, submit copy of the Workers' Compensation Award and dates of payment (check copies).

SECTION I (To be completed by employee-PLEASE PRINT).

1. Name of Employee

2. Employee's Address — Home Phone

3. Name of Employer — Local #

4. Employer's Address — Employer's Phone

5. Social Security Number — Date of Birth

SECTION II (Complete only if injury or illness occurred on the job).

6. Date of injury — Day of Week — Hour of Day — a.m./p.m.

7. Date disability began — a.m./p.m. — When did you or a foreman first know of injury?

8. Describe fully how accident occurred, and state what employee was doing when injured.

9. Last day worked — Job site

10. Name and address of physician who treated you — If hospitalized, name and address of hospital.

SECTION III (Complete for non-job related injury or illness).

11. Nature of illness or injury — Last day worked

12. If accident (describe)

SECTION IV (To be completed by attending physican).

13. Diagnosis and concurrent conditions

14. Date symptoms first appeared or accident happened — First date of treatment

15. Patient was continuously totally disabled (unable to work) From_____ thru_____ — If still disabled, date patient should be able to return to work _____

Physican Name (Print) _____ Date _____

Physican Signature _____ Phone _____

Street_____ City _____ State_____ Zip _____

I understand that I am not entitled to be paid Weekly Disability payments by the Warehouse Employees Union Local No. 730 Health and Welfare Fund for the same dates that I receive: (1) Pension payments from the Warehouse Employees Unon Local No. 730 Pension Fund, or (2) Social Security Disability Award payments. I acknowledge that I am required to notify the Fund Office, in writing, within 10 days, if I receive a Social Security Disability Award. I also understand that failure to respond to requests for additional information, or to return benefit payments paid for the same period of time that I was collecting pension payments or Social Security disability, may result in a suspension of benefits under the Welfare plan.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical facility, insurance company, government agency or other institution or person that has any record or knowledge of me or my health to give any such information to the Warehouse Employees Union Local No. 730 Health and Welfare Trust Fund. A photostatic copy of this authorization shall be as valid as the original. It shall remain effective for one year from the date of authorization.

Date _____ Employee Signature _____