OPERATING ENGINEERS TRUST FUND
WEEKLY ACCIDENT & SICKNESS AND/OR MAINTENANCE OF BENEFITS FORM

Send claims to:
THE FUND OFFICE
P.O. Box 1064
Sparks, MD 21152-1064
(877) 850-0977

THIS SIDE TO BE COMPLETED BY EMPLOYEE (Please Print Clearly)

Name and Home Address of Employee (Print)	
Mr. Mrs. Miss _____	Local Union No. _____
Street Address _____	Social Security No. _____
City/State/Zip Code _____	Date of Birth _____ Month Day Year

LIST ALL EMPLOYERS DURING PAST THREE MONTHS — START WITH PRESENT

Employer Name, City, State	Phone Number	From		To	
		Yr.	Mo.	Yr.	Mo.
1.					
2.					
3.					

NATURE OF ILLNESS OR DISABILITY

Last Day Worked:	Cause of Disability: _____
_____ Month Day Year	

If disability is due to an accident, state when, where and how it occurred: _____

Was illness or injury due, in any way, to your occupation? ❒ Yes ❒ No
If "YES" explain _____

Date returned to work:	If you have filed for Workers' Compensation, complete the following:		Date Filed:
	Claim No.	Insurance Company Name and Address:	
Month Day Year			Mo. Day Yr.

Are you receiving Unemployment Compensation? ❒ Yes ❒ No

AUTHORIZATION AND CERTIFICATION

I hereby authorize any insurance company, prepayment organization, employer, hospital or physician to release any and all information with respect to this claim which may be necessary to determine any amount payable. I certify that the above statements and information are correct.

_____ Signed at _____ on _____
Signature of Employee City and State Mo. Day Yr.

FOR PHYSICIAN ONLY – PHYSICIAN MUST SIGN AND COMPLETE THIS SECTION

PATIENT'S NAME AND ADDRESS:	SOCIAL SECURITY NUMBER	AGE

DATE OF: ❒ ILLNESS (FIRST SYMPTOM)
❒ INJURY (ACCIDENT)
❒ PREGNANCY (LMP)

DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION:

HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS?

❒ YES ❒ NO

IF AN EMERGENCY CHECK HERE ☐

DATE PATIENT ABLE TO RETURN TO WORK:

_____

DATES OF TOTAL DISABILITY:

FROM _____ THROUGH _____

NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. public health agency)

NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (if other than home or office)

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. PLEASE BE SPECIFIC.

DATES OF TREATMENT SINCE THE DISABILITY BEGAN (list each date)

IS THE DISABILITY THE RESULT OF AN ACCIDENT? ❒ YES ❒ NO

AUTO ACCIDENT? ❒ YES ❒ NO WORK RELATED? ❒ YES ❒ NO

ON WHAT DATE DID THE ACCIDENT OCCUR? _____

WAS SURGERY PERFORMED? ❒ YES ❒ NO

IF YES, TYPE OF SURGERY _____

❒ INPATIENT DATE ADMITTED _____ DATE DISCHARGED _____

SIGNATURE OF PHYSICIAN:

SIGNED _____ DATE _____ SOCIAL SECURITY NUMBER _____

PHYSICIAN'S NAME, ADDRESS, ZIP CODE & PHONE NUMBER:

_____

YOUR PATIENT'S ACCOUNT NUMBER: _____

YOUR EMPLOYER I.D. NUMBER: _____