Steamfitters Local #449

BENEFIT FUNDS

c/o Frank M. Vaccaro & Associates, Inc.
1517 Woodruff Street
Pittsburgh, PA 15220-5305

Telephone: (412) 481-0300
Toll Free: (888) 355-5665
Fax: (412) 381-6132

Disability Claim Application

Delay in Payment May Occur if Form is Not Complete

Part A To be Completed by Member

1. Name Last First Middle		2. Date of Birth	3. Social Sec No.
4. Address Street City State Zip Code			5 Telephone
6. Local Union	7. Name of Last Employer	8. Last Day Worked	9. Type of Injury or Illness
10. Nature of Illness or Injury (circle one) Illness Off Job Injury Auto Accident Work Related Injury **Complete No. 11 if Auto Accident or Work Injury**		11. Workers Compensation Ins. or Auto Ins. Carrier Address Telephone Claim #	
12. Date of Injury or Illness			

PLEASE READ CAREFULLY BEFORE SIGNING: I hereby certify the information contained herein is true and correct. I further certify that I am NOT filing for unemployment compensation benefits for this period of disability that I am filing an Accident or Sickness Benefits claim with the Steamfitters Local #449 Medical & Benefit Plan ("Plan"). I hereby authorize all insurers, doctors, pharmacists, hospitals, government agencies or other parties providing coverage, care and treatment, to furnish the Plan or its insurers with full information regarding benefits provided or treatment rendered. A copy or photocopy of this authorization shall be considered as effective and valid as the original.

Furthermore, if I have filed a claim for Workers' Compensation benefits or intend to assert a third party claim arising from this accident, I hereby agree to immediately reimburse the Plan should I recover any Workers' Compensation benefits or receive any settlement in a third party claim on a first dollar basis. In addition, I authorize and direct the Plan as well as the Steamfitters Local #449 Pension Fund and/or Retirement Security Fund to forward to the Plan any monies payable to me, or my dependents, to be applied toward such reimbursements, or the Plan may impose a constructive trust on such monies.

With intent to be legally bound hereby:

_____ _____

Date Signature of Employee or Authorized Agent

Part B To be completed by Attending Legally Licensed and Qualified Physician

1. Primary Diagnosis	3. Name of Hospital if Applicable Date Admitted Date Discharged
2. Secondary Diagnosis	
4. Date first seen by Physician	5. Dates of Total Disability From To
6. Best Estimate of Length of Time Until Patient Will be Able to Return to Work Months Weeks	

Physician's Name (with Credentials) _____ Phone _____

Address _____

Signature _____ Date _____

Remarks _____