INSTRUCTION TO EMPLOYEE

1. This form is to be filed as soon as it appears that you will qualify for disability benefits.
2. Complete the Statement of Employee and the Authorization for Release of information below.
3. Have your physician complete the Attending Physician's Statement below.
4. Return this Form to the Benefits office.

STATEMENT OF EMPLOYEE		
Your Name:	Telephone Number: ( )	
First Date of Total Disability:	Date of Birth: / /	SSN:
Is disability due to ____accident or ____sickness (If accident describe, including date and place, if sickness when did symptoms first appear?)		
Did disability result from employment?		
These statements are true and complete to the best of my knowledge: Signature of Employee Today's Date		

AUTHORIZATION FOR RELEASE OF INFORMATION			
In order to process a claim for benefits. I authorize any physician, hospital or other medical provider to release to the Fund Office or its representative, any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered valid for the duration of the claim, but not to exceed one year from date I signed. I understand I have the right to receive a copy of this authorization.			
Signature of Employee Today's Date			
Address of Employee			
Street	City	State	Zip
Is this a new address? Yes or No			

ATTENDING PHYSICIAN'S STATEMENT
1. Diagnosis and concurrent conditions (If diagnosis code other than ICOA used, give name):
2. Is condition due to injury or sickness arising out of patient's employment? _____ Pregnancy? Yes or No If yes, approximate date pregnancy commended:
3. Date symptoms first appeared or accident happened:
4. Patient ever had same or similar condition? Yes or No If yes, when and describe:
5. Patient still under your care for this condition? Yes or No
6. **Patient was continuously totally disabled (unable to work) From: Through:**

PHYSICIAN'S INFORMATION			
Name (Print)	Signature	Today's Date	Telephone Number
Street Address	City or Town	State	Zip Code