WEEKLY ACCIDENT AND SICKNESS
NON-OCCUPATIONAL DISABILITY BENEFIT CLAIM FORM

HEATING, PIPING & REFRIGERATION MEDICAL FUND

9411 Philadelphia Road, Suite S, Baltimore, Maryland 21237 Tel: 1-800-618-2879

INSTRUCTIONS: This form is to be used to submit a claim for the weekly accident and sickness disability income benefits which are payable when an employee is unable to work on account of a non-occupational illness or injury. The completed form should be submitted to the Medical Fund Office at the address indicated above. To avoid having your claim returned, PLEASE BE SURE ALL INFORMATION IS CORRECT AND COMPLETE.

TO BE COMPLETED BY MEMBER

1. Members Name & Address:

2. Social Security No.:
3. Date of Birth:
4. Home Telephone No.:
5. Employer

6. Describe symptoms of illness or injury_____

7. Was condition a result of an accidental injury? ❒ Yes ❒ No If Yes, complete the following:

   Date of injury_____ Place of injury_____

   Describe how injury occurred_____

8. Date you were first unable to return to work_____

   Are you still unable to work because of your disability? ❒ Yes ❒ No

   If No, give date you returned or were able to return to work_____

   If Yes, when do you expect to return to work_____

9. Was illness or injury caused by employment? ❒ Yes ❒ No If yes, do not submit claim to Medical Fund. Submit to your employer's worker's compensation insurance company.

I certify that the above information is correct and that I have coverage with the Medical Fund. I apply for weekly accident and sickness benefits under this coverage with the understanding that these benefits are payable only during the period that I am unable to work due to a non-occupational injury or illness. I agree to notify the Medial Fund Administrative Office of the date I return or an able to return to work if such date is not indicated above. I further agree if I receive payments for any period after the date of my recovery, I will return the payments to the Medical Fund.

Date_____ Signature of Member_____

This section must be completed by the physician every 30 days in order for disability benefits to continue.

1. Diagnosis and concurrent conditions_____ Diagnosis Code_____

2. Date symptoms first appeared or accident happened_____

3. Date patient first consulted you for this condition_____

4. Has patient ever had same or similar condition? ❒ Yes ❒ No

5. Is patient still under your care for this Condition? ❒ Yes ❒ No

   If Yes, when and describe:_____

6. Dates patient was continuously disabled (Unable to work)
   From: _____ Thru: _____

7. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK_____

8. Physician's Name (print)_____

9. Physician's Telephone No._____

10. Physician's address_____

Date_____ Signature of Physician_____