ARIZONA SHEET METAL TRUST FUNDS

HEALTH AND WELFARE | ADMINISTRATIVE OFFICE | PENSION

2400 W. Dunlap Ave., Suite 250
Phoenix, AZ 85021
(602) 249-3582

PARTICIPANT STATEMENT:

DISABILITY / TIME LOSS BENEFITS

PART A EMPLOYEE'S STATEMENT (MUST BE COMPLETED BY EMPLOYEE)

1. EMPLOYEE NAME (PLEASE PRINT)	2. BIRTH DATE MO. DAY YR	3. SOCIAL SECURITY NO. / /
4. ADDRESS ☐ CHECK HERE IF NEW ADDRESS CITY STATE ZIP		5. PHONE NO. ( )
6. EMPLOYER (Or Company you work for)		
6 a. ADDRESS CITY STATE ZIP		7. PHONE NO. ( )

8. IS THIS CLAIM FOR AN ACCIDENT? ☐ YES ☐ NO

9. IF YES – WHERE DID IT HAPPEN?

10. WHEN? MO DAY YR	**11. DID THIS ACCIDENT/INJURY OCCUR ON THE JOB?** ☐ YES ☐ NO

12. NAME AND ADDRESS OF PERSON RESPONSIBLE FOR ACCIDENT OR INJURY:

13. NAME, ADDRESS AND CLAIM NUMBER OF RESPONSIBLE PERSON'S INSURANCE COMPANY:

14. EMPLOYEE STATEMENT AND AUTHORIZATION TO RELEASE INFORMATION:

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct, and complete. I hereby authorize any physician or any hospital to furnish and disclose all known facts concerning this disability. I will reimburse the fund for any overpayment made to me or in my behalf due to error on this form. I understand that it is a federal crime, punishable by fine or imprisonment, or both, to knowingly make false statements on this benefit claim form.

_____ Employee Signature

_____ Date

CLAIM CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE

EMPLOYER / HUMAN RESOURCE STATEMENT:

PART B (MUST BE COMPLETED BY EMPLOYER / HUMAN RESOURCE DEPARTMENT)

1. LAST DAY WORKED	2. DATE RETURNED TO WORK	3. DID INJURY OCCUR ON THE JOB? ☐ YES ☐ NO	
4. COMPANY NAME	5. SIGNED BY	6. TITLE	7. DATE

PART C PHYSICIAN'S STATEMENT FOR SHORT-TERM DISABILITY

(MUST BE COMPLETED BY PHYSICIAN FOR PATIENT BEING DISABLED 6 MONTHS OR LESS)

1. PATIENT'S NAME: (PLEASE PRINT)		2. SOCIAL SECURITY NUMBER:
3. ICD.9 CODE WITH DESCRIPTION	4. IF DIAGNOSIS IS PREGNANCY, PLEASE LIST DUE DATE:	
5. DATE PATIENT DISABLED FROM WORK:	6. *DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK: ***MANDATORY**	7. DATE PATIENT RELEASED TO RETURN TO WORK:
8. FEDERAL TAX ID NUMBER:	9. PHONE NUMBER:	10. FAX NUMBER:
11. PHYSICIAN NAME & ADDRESS: (PRINT)	12. PHYSICIAN'S SIGNATURE:	13. DATE: