

# SMWIA Local 49 Family Health Plan

Administrative Office  
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**PARTICIPANT STATEMENT:**

## DISABILITY CLAIM FORM

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

<b>1. EMPLOYEE NAME (PLEASE PRINT)</b>		<b>2. BIRTH DATE</b> MO.      DAY      YR	<b>3. SOCIAL SECURITY NO.</b> /      /
<b>4. ADDRESS</b>	<input type="checkbox"/> CHECK HERE IF NEW ADDRESS	CITY      STATE      ZIP	<b>5. PHONE NO.</b>  (      )
<b>6. EMPLOYER</b> (Or Company you work for)			
<b>6 a. ADDRESS</b>	CITY      STATE      ZIP	<b>7. PHONE NO.</b> (      )	
<b>8. IS THIS CLAIM FOR AN ACCIDENT?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO			
<b>9. IF YES – WHERE DID IT HAPPEN?</b>			
<b>10. WHEN?</b> MO      DAY      YR	<b>11. DID THIS ACCIDENT/INJURY OCCUR ON THE JOB?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		
<b>12 NAME AND ADDRESS OF PERSON RESPONSIBLE FOR ACCIDENT OR INJURY:</b>			
<b>13. NAME, ADDRESS AND CLAIM NUMBER OF RESPONSIBLE PERSON'S INSURANCE COMPANY</b>			
<b>14. EMPLOYEE STATEMENT AND AUTHORIZATION TO RELEASE INFORMATION:</b> 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			

**HUMAN RESOURCE STATEMENT:**

<b>PART B      (MUST BE COMPLETED BY EMPLOYER)</b>			
<b>1. LAST DAY WORKED</b>	<b>2. DATE RETURNED TO WORK</b>	<b>3. DID INJURY OCCUR ON THE JOB?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>4. WEEKLY WAGE</b>
<b>5. COMPANY NAME</b>	<b>6. SIGNED BY</b>	<b>7. TITLE</b>	<b>8. DATE</b>

<b>PART C                      PHYSICIAN'S STATEMENT FOR SHORT-TERM DISABILITY</b> <i>(MUST BE COMPLETED BY PHYSICIAN FOR PATIENT BEING DISABLED 6 MONTHS OR LESS)</i>		
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:

**\*\*\*IMPORTANT\*\*\***

**PHYSICIAN PLEASE NOTE: IF THIS IS A NON SURGICAL DISABILITY, PLEASE ATTACH LATEST OFFICE NOTES, INCLUDING RETURN TO WORK TREATMENT PLAN.**