

# UNITED FOOD AND COMMERCIAL WORKERS & EMPLOYERS

## Arizona Health & Welfare Trust

ADMINISTRATOR: Southwest Service Administrators, Inc.  
 2400 W. Dunlap Ave., Suite 250 • Phoenix, AZ 85021 • Phone 602-249-3582 • Toll Free 1-800-474-3485 • Fax 602-249-3795



### PARTICIPANT STATEMENT:

## DISABILITY CLAIM FORM (108-13)

<b>PART A</b>			<b>EMPLOYEE'S STATEMENT</b>			<b>(MUST BE COMPLETED BY EMPLOYEE)</b>		
1. EMPLOYEE NAME (PLEASE PRINT)				2. BIRTH DATE MO.      DAY      YR		3. SOCIAL SECURITY NO. /                   /		
4. ADDRESS <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO								
9. IF YES – WHERE DID IT HAPPEN?								
10. WHEN? MO      DAY      YR			11. DID THIS ACCIDENT/INJURY OCCUR ON THE JOB? <input type="checkbox"/> YES <input type="checkbox"/> 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			
<b>CLAIM CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE</b>								

### HUMAN RESOURCE STATEMENT:

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