UFCW UNIONS AND EMPLOYERS HEALTH AND WELFARE PLAN OF CENTRAL OHIO

APPLICATION FOR ACCIDENT AND SICKNESS BENEFIT

1. TO BE COMPLETED BY EMPLOYEE

_____ _____ (___)_____
Insured name Insured Social Security Home Phone

_____ _____ (___)_____
Insured Address City, State, Zip Work Phone

____/____/_____ Married/Single/Divorced _____
Date of Birth Status Employer

Do you have any other employment? ☐ yes ☐ no

Is condition related to: ☐ employment ☐ auto accident ☐ other accident

Date of accident:____/____/_____ Where did accident occur?_____

Describe circumstance:_____

2. TO BE COMPLETED BY EMPLOYER

_____ $_____
Name of employee Basic weekly earnings

Date of first full day unable to work_____

Was this illness/injury reported as work related? ☐ yes ☐ no

Has employee returned to work ☐ yes ☐ no If yes, please advise date returned to work_____

If not returned to work, date expected to return_____

Employer_____ By_____

Date_____ Phone_____

PLEASE RETURN THIS COMPLETED FORM TO:
UFCW Unions and Employers
Health and Welfare Plan of Central Ohio
4150 East Main Street, 1st Floor, Columbus, Ohio 43213
Phone: (614) 237-7618 Fax: (614) 338-0226

CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION

I certify that the answers on this form are true and correct to the best of my knowledge. I understand that it is illegal to file a false or fraudulent claim or to knowingly help someone else file one.

I authorize my employer or any physician, hospital, clinic, or other medical provider to release any information requested with respect to this application for accident and sickness benefits to the UFCW Unions and Employers Health and Welfare Plan of Central Ohio (the "Plan"), its authorized representative or its legal representative.

I understand the information obtained by use of the Authorization will be used by the Plan to determine eligibility for accident and sickness benefits. Information obtained will not be released EXCEPT to protect the Plan's subrogation rights and its rights to reimbursement or as may be otherwise lawfully required.

I know that I may request a copy of this Authorization. **I agree** that a photographic copy of this Authorization is as valid as the original.

Employee signature_____ Date_____

3. TO BE COMPLETED BY ATTENDING PHYSICIAN

_____ _____

Patient name Description of disabling condition(s) (ICD-9 or other)

Patient continuously totally disabled (unable to work) From_____Thru_____

If still disabled, date patient able to return to work?_____

Is condition due to injury? ☐Yes ☐ No Pregnancy? ☐ Yes ☐ No

If pregnancy, expected date of delivery_____

Any complications?_____

Date symptoms first appeared_____Date physician first consulted_____

Is patient still under your care for this condition? ☐ Yes ☐ No Next scheduled appointment_____

Dates of service during the period disabled_____

Has patient been hospitalized during this period: Admit_____ Discharge_____

Has patient undergone surgery for this condition? ☐ Yes ☐ No If yes, date_____

What is the ongoing treatment / therapy plan? Please provide details_____

_____

Physician Name_____Tax ID#_____

Address_____

Phone Number_____Fax Number_____

_____ _____

Signature of Physician Date