Statement of Claim

Disability Income Benefits

Limited to 26 weeks maximum benefit.

UA LOCAL 13 FUND OFFICE

1850 MT. READ BLVD

ROCHESTER, NY 14615

Part A TO BE COMPLETED BY INSURED MEMBER **PLEASE PRINT**

1. Name	2. Address	3. Social Security No.

4. Was illness or injury connected with employment? ☐ No ☐ Yes ☐ Unknown	5. Is this claim related to or based on a motor vehicle accident? ☐ No ☐ Yes	6. Date of birth

7. Is this claim based on an accident? ☐ Yes ☐ No

If Yes, Give Date _____ 19____ and Time _____ ☐ A.M. ☐ P.M.

Where did accident occur? _____

How did accident happen? _____

NOTE: A Disability check or Workmens' Compensation check or other proof of disability is required to complete this claim. See Section VI, Paragraph A-3 of the Insurance Summary Plan Description for details.

8. I authorize the release of any medical information necessary to process this claim.

Signed (insured member only) _____

Reimbursement Agreement

The undersigned plan participant requests that the U.A. Local 13 and Employers Group Insurance Fund pay applicable benefits under its Weekly Disability Provisions (see Summary Plan Description) on account of the disability described herein.

For, and in consideration of, the payment(s) made by the U.A. Local 13 and Employers Group Insurance Fund, pursuant to the terms of the Plan Provisions, the undersigned plan participant hereby agrees to reimburse the U.A. Local 13 and Employers Group Insurance Fund to the extent of any benefits paid based on erroneous information provided to the Fund.

And further, the undersigned plan participant hereby agrees to reimburse the U.A. Local 13 and Employers Group Insurance Fund to the extent of any benefits paid, upon the settlement by formal award, informal compromise, redemption agreement, or otherwise, of either a No-Fault motor vehicle accident or a Workmens' Compensation case, in which lost wages are paid to the participant by either a No-Fault carrier or a Workmens' Compensation carrier.

_____

Signature of Plan Participant Date

***Note:* All items must be completed before claim will be processed**

Part B TO BE COMPLETED BY PHYSICIAN

9. ☐ ILLNESS _____ DATE OF FIRST SYMPTOMS
☐ INJURY _____ DATE OF ACCIDENT
☐ PREGNANCY _____ DATE OF LMP
☐ MOTOR VEHICLE ACCIDENT _____ DATE

10. DATE FIRST CONSULTED YOU FOR THIS CONDITION	11. DATES OF PATIENT'S DISABILITY ▶	FROM DATE	THROUGH DATE

12. DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK	13. MEMBER ONLY DATE LAST WORKED

14. FOR SERVICES RELATED TO HOSPITALIZATION STATE HOSPITALIZATION DATES	DATE ADMITTED	DATE DISCHARGED

15. **(DIAGNOSIS OR NATURE OF ILLNESS OR INJURY)**

1.

2.

16. PHYSICIANS NAME, ADDRESS, ZIP CODE & TELEPHONE NO. (Please type or print)	17. SOCIAL SECURITY NO.
	18. EMPLOYER I D NO.
	19. OTHER IDENTIFYING NO.

20. SIGNATURE OF PHYSICIAN SIGN HERE ▶	21. DATE SIGNED