Sheet Metal Workers' Local 36 Benefit Funds
2319 Chouteau Ave., Ste. 300
St. Louis, MO 63103
(314) 652-8175 (800) 741-9411

SHEET METAL | AIR | RAIL | TRANSPORTATION

SMART

SHEET METAL WORKERS | LOCAL UNION NO. 36

Please fax or email completed form:
FAX: 314-241-4049
EMAIL: mbcyliax@sheetmetal36.org

Accident & Sickness Temporary Disability Form

MEMBER'S NAME

SOCIAL SECURITY NO.

DATE OF BIRTH / /

ADDRESS

PHONE

- Is this claim based on an accident? ☐ Yes ☐ No

  IF YES: DATE OF OCCURRENCE: ____/____/____ WHERE DID INJURY OCCUR:_____

  HOW DID INJURY OCCUR:_____

  _____

  WAS A THIRD PARTY AT FAULT? ☐ Yes ☐ No

- ***Is it in any way related to your employment?*** ☐ Yes ☐ No

I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment that would be necessary to determine benefits.

I hereby certify that the facts stated in all of the above listed statements are true, factual, and complete.

MEMBER'S SIGNATURE

DATE / /

ATTENDING PHYSICIAN'S STATEMENT—DISABILITY CLAIM

1. Diagnosis_____
2. If surgery is required, date of surgery_____
3. Date symptoms first appeared or accident happened_____
4. Date patient first consulted you for this condition_____
5. Has patient ever had same or similar condition ☐ Yes ☐ No

   If yes, when—and please describe_____
6. Is patient still under your care for this condition ☐ Yes ☐ No If Yes, when is next scheduled visit_____
7. Patient was continuously disabled: (unable to work, there is no light duty in the sheet metal trade) from_____ through_____
8. If still disabled, date patient should be able to return to work (estimate if unsure)_____

PHYSICIAN'S SIGNATURE

DATE / /

PHYSICIAN'S NAME , PHONE NUMBER

ADDRESS