KENTUCKY LABORERS DISTRICT COUNCIL HEALTH & WELFARE FUND

1996 BY PASS SOUTH
LAWRENCEBURG, KENTUCKY 40342

Phone: (502) 839-8166

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CLAIM FORM FOR ACCIDENTAL DISMEMBERMENT BENEFIT

PART 1

(TO BE COMPLETED IN FULL AND SIGNED BY MEMBER)

MEMBER=S NAME Last: First: MI.:	SOC. SEC. #	PHONE # ( )
ADDRESS Street/P.O.Box: City: State: Zip:		

TYPE OF ACCIDENTAL DISMEMBERMENT (/):

- ☐ Both Hands
- ☐ Both Feet
- ☐ Both Eyes
- ☐ One Hand and One Foot
- ☐ One Hand and One Eye
- ☐ One Hand
- ☐ One Foot
- ☐ One Eye
- ☐ Thumb and Index Finger of Either Hand
- ☐ Any Two Fingers

NOTE: Loss of hand or hands, or foot or feet, means severance at or above wrist joint or ankle joint, respectively. The loss of thumb and index finger means severance of two or more entire phalanges of both the thumb and index finger. The loss of any two (2) fingers means severance of two or more entire phalanges of each severed finger. The loss of eye or eyes means the total and irrecoverable loss of the entire sight thereof.

DATE DISMEMBERMENT OCCURRED: _____

INFORMATION REGARDING THE PHYSICIAN WHO IS TREATING YOU FOR THIS INJURY:

Name:_____
Street Address:_____
City:_____State:_____Zip:_____Phone #:_____

Date You Were First Treated by This Physician For This Injury: _____

WAS DISMEMBERMENT DUE TO AN ACCIDENT? (/) Yes ☐ No ☐

IF YOU ANSWERED AYES@ TO THE QUESTION ABOVE, PLEASE GIVE ACCIDENT INFORMATION AS FOLLOWS:

When did accident happen?	
Where did accident happen?	
How did accident happen?	
Was injury work-related?	

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I HEREBY AUTHORIZE ALL PHYSICIANS, HOSPITALS, OR OTHER PROVIDERS RENDERING TREATMENT TO FURNISH THE KENTUCKY LABORERS DISTRICT COUNCIL HEALTH AND WELFARE FUND WITH FULL INFORMATION REGARDING TREATMENT RENDERED (INCLUDING COPIES OF MEDICAL RECORDS). i AUTHORIZED ANY UNION, TRUST FUND, ASSOCIATION, EMPLOYER, PROVIDER OF SERVICE OR INSURANCE CARRIER TO FURNISH THE KENTUCKY LABORERS DISTRICT COUNCIL HEALTH AND WELFARE FUND WITH INFORMATION REGARDING BENEFITS TO WHICH I MAY BE ENTITLED OR HAVE RECEIVED. A PHOTOSTATIC COPY HEREOF SHALL BE AS VALID AS THE ORIGINAL.

_____ _____

DATE SIGNATURE OF MEMBER

PART 2
(TO BE COMPLETED IN FULL AND SIGNED BY ATTENDING PHYSICIAN)

1. Patient's Name: _____ Soc. Sec. #: _____
(Last) (First) (M.I.)

2. Diagnosis: _____

3. Please provide the following information regarding treatment of the patient:

   a. Date of first visit for this condition: _____

   b. Date of most recent visit for this condition: _____

   c. Type of Dismemberment (/):

☐ Both Hands	☐ One Hand
☐ Both Feet	☐ One Foot
☐ Both Eyes	☐ One Eye
☐ One Hand and One Foot	☐ Thumb and Index Finger of Either Hand
☐ One Hand and One Eye	☐ Any Two Fingers

NOTE: For consideration of eligibility for the Accidental Dismemberment Benefit, please note the following:

a. **Loss of hand or hands, or foot or feet** means severance at or above wrist joint or ankle joint, respectively.
b. **The loss of thumb and index finger** means severance of two or more entire phalanges of both the thumb and index finger.
c. **The loss of any two (2) fingers** means severance of two or more entire phalanges of each severed finger.
d. **The loss of eye or eyes** means the total and irrecoverable loss of the entire sight thereof.

d. Was dismemberment due to accident? Yes ☐ No ☐

e. Date of the accident: _____ Date of dismemberment: _____

f. Please give description of treatment given for this disability:

_____

_____

_____

_____
Date

Signature of Attending Physician

_____
Name of Physician (Please Print)

_____
Mailing Address

_____
City State Zip