RETURN COMPLETED FORM TO:

KENTUCKY LABORERS DISTRICT COUNCIL HEALTH & WELFARE FUND
1996 Bypass South
Lawrenceburg, KY 40342-9754

Phone: (502) 839-8166 Fax: (502) 839-3558

STATEMENT OF DISABILITY

FOR ACTIVE ACCIDENT & SICKNESS WEEKLY DISABILITY BENEFIT

CLAIM FORM MUST BE COMPLETED IN FULL, SIGNED BY PARTICIPANT AND ATTENDING PHYSICIAN AND SUBMITTED TO THE FUND WITHIN NINETY (90) DAYS OF OCCURRENCE OF CLAIM

TO BE COMPLETED BY COVERED PARTICIPANT

1. Participant's Full Name: _____ Participant's Soc Sec #: _____
2. Participant's Address: _____
   [Street or P. O. Box] [City] [State] [Zip Code]
3. Are you still totally disabled by this sickness or Injury? _____YES _____NO
4. Are you now wholly unable to physically engage in any work, occupation or business? _____YES _____NO
5. Is this injury / sickness related to Participant's work? _____YES _____NO
6. Have you returned to work? _____YES _____NO

   If you answered "YES", what date did you return to work? Return to Work Date: _____
   [Mo/Day/Yr]

SIGNATURE OF PARTICIPANT: _____ DATE SIGNED: _____

TO BE COMPLETED BY PARTICIPANT'S ATTENDING PHYSICIAN

1. Patient's Full Name: _____ Patient's DOB: _____
2. (a) Nature of Sickness or Injury (Describe complications, if any): _____

   _____

   (b) Diagnosis Code(s): _____
3. (a) Date of first treatment: _____

   (b) Date of most recent treatment: _____

   (c) Frequency of treatments: _____
4. The Patient has been continuously disabled and unable to work: From: _____ [Mo/Day/Yr] Through: _____ [Mo/Day/Yr]
5. If Patient is still disabled, when will patient be able to return to work?: Date: _____ [Mo/Day/Yr]
6. Remarks: _____

   _____

   _____

SIGNATURE OF ATTENDING PHYSICIAN: _____ DATE: _____

ATTENDING PHYSICIAN' NAME [Please Print]: _____ DEGREE: _____

ADDRESS: _____

PHONE #: _____ FAX #: _____ EMAIL: _____