

SMWIA Local 49 Family Health Plan

Administrative Office
4775 Indian School Road, NE • Suite 105 • Albuquerque, New Mexico 87110
Phone 505-265-8422 • Toll Free 1-800-432-6636

PARTICIPANT STATEMENT:

DISABILITY CLAIM FORM			
PART A EMPLOYEE'S STATEMENT		(MUST BE COMPLETED BY EMPLOYEE)	
1. EMPLOYEE NAME (PLEASE PRINT)		2. BIRTH DATE MO. DAY YR	3. SOCIAL SECURITY NO. / /
4. ADDRESS	<input type="checkbox"/> CHECK HERE IF NEW ADDRESS	CITY STATE ZIP	5. PHONE NO. ()
6. EMPLOYER (Or Company you work for)			
6 a. ADDRESS		CITY STATE ZIP	7. PHONE NO. ()
8. IS THIS CLAIM FOR AN ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			
9. IF YES – WHERE DID IT HAPPEN?			
10. WHEN? MO DAY YR	11. DID THIS ACCIDENT/INJURY OCCUR ON THE JOB? <input type="checkbox"/> YES <input type="checkbox"/> NO		
12. NAME AND ADDRESS OF PERSON RESPONSIBLE FOR ACCIDENT OR INJURY:			
13. NAME, ADDRESS AND CLAIM NUMBER OF RESPONSIBLE PERSON'S INSURANCE COMPANY			
14. EMPLOYEE STATEMENT AND AUTHORIZATION TO RELEASE INFORMATION: I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct, and complete. I hereby authorize any physician or any hospital to furnish and disclose all known facts concerning this disability. I will reimburse the fund for any overpayment made to me or in my behalf due to error on this form. I understand that it is a federal crime, punishable by fine or imprisonment, or both, to knowingly make false statements on this benefit claim form.			
_____		_____	
Employee Signature		Date	
CLAIM CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE			

HUMAN RESOURCE STATEMENT:

PART B (MUST BE COMPLETED BY EMPLOYER)			
1. LAST DAY WORKED	2. DATE RETURNED TO WORK	3. DID INJURY OCCUR ON THE JOB? <input type="checkbox"/> YES <input type="checkbox"/> NO	4. WEEKLY WAGE
5. COMPANY NAME	6. SIGNED BY	7. TITLE	8. DATE

PART C PHYSICIAN'S STATEMENT FOR SHORT-TERM DISABILITY <i>(MUST BE COMPLETED BY PHYSICIAN FOR PATIENT BEING DISABLED 6 MONTHS OR LESS)</i>		
1. PATIENT'S NAME (PLEASE PRINT)		2. SOCIAL SECURITY NUMBER:
3. ICD.9 CODE WITH DESCRIPTION		4. IF DIAGNOSIS IS PREGNANCY, PLEASE LIST DUE DATE:
5. DATE PATIENT DISABLED FROM WORK:	6. *DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK *MANDATORY	7. DATE PATIENT RELEASED TO RETURN TO WORK:
8. FEDERAL TAX ID NUMBER:	9. PHONE NUMBER:	10. FAX NUMBER
11. PHYSICIAN NAME & ADDRESS (PRINT)	12. PHYSICIAN'S SIGNATURE	13. DATE:

******IMPORTANT******

PHYSICIAN PLEASE NOTE: IF THIS IS A NON SURGICAL DISABILITY, PLEASE ATTACH LATEST OFFICE NOTES, INCLUDING RETURN TO WORK TREATMENT PLAN.