PLUMBERS & PIPEFITTERS MEDICAL FUND

7130 Columbia Gateway Drive, Suite A, Columbia, MD 21046 • 1-800-741-9249

OCCUPATIONAL GROUP PROOF OF CLAIM AND PHYSICIAN'S STATEMENT

INSTRUCTIONS:

1. Complete Section 1 and have your physician complete Section II.
2. Submit the completed form to the Medical Fund after you have filed a claim with the Employee's Workers Compensation Carrier.
3. **Send in a copy of your last compensation check along with this form.**

SECTION I (To be completed by Employee – Please Print or Type)

1. Name of Employee	4. Employer
2. Employee's Address	5. Employer Address
3. Job Classification (A Foreman, Journeyman, Apprentice Trainee or OTHER)	6. Employer Phone No. ( )
	7. Workers Compensation Carrier / Policy No.

8. Employee Social Security No.	9. Employee's Home Telephone No.	10. Employee's Date of Birth	11. Hourly Wage

12. Date of Injury _____, 19____ Day of week _____ Hour of day _____ A.M. _____ P.M.

13. Date disability began _____, 19____ ____A.M. ____P.M. Were you paid in full for this day _____

14. When did you or foreman first know of injury _____

15. Name of foreman _____

16. Describe fully how accident occurred, and state what employee was doing when injured _____

_____

_____

17. Address of job site: _____

18. NAME AND ADDRESS OF PHYSICIAN WHO FIRST TREATED YOU	19. IF HOSPITALIZED, GIVE NAME AND ADDRESS OF HOSPITAL

20. WORKERS COMPENSATION CARRIER REPRESENTATIVE

PHONE NO.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, government agency or other organization, institution or person that has any record or knowledge of me or my health to give any such information to the Plumbers and Pipefitters Medical Fund. A photostatic copy of this authorization shall be as valid as the original. It shall remain effective for one year from the date of authorization.

DATE	EMPLOYEE'S SIGNATURE

SECTION II (To be completed by attending physician)

1. Diagnosis and concurrent conditions	Diagnosis Code

2. Date symptoms first appeared or accident happened	3. Date patient first consulted you for this condition.
4. Patient ever had same or similar condition? ☐ Yes ☐ No If "Yes" when and describe:	5. Patient still under your care for this condition? ☐ Yes ☐ No
6. Patient was continuously totally disabled (Unable to work) From: Thru:	7. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK.

DATE	PHYSICIAN'S NAME (Print)	SIGNATURE	DEGREE	TAX ID NO.	TELEPHONE

Street Address	City or Town	State	Zip Code