SUBURBAN TEAMSTERS OF NORTHERN ILLINOIS WELFARE FUND
1171 COMMERCE DRIVE, UNIT 1
WEST CHICAGO, IL 60185-2680
Tel. (630)293-5218; FAX (630)293-5845
Office Hours: Monday through Friday
8:00 a.m. – 5:00 p.m.

LOSS OF TIME DISABILITY APPLICATION/UPDATE FORM

UPPER PORTION TO BE COMPLETED BY MEMBER

MEMBERS FULL NAME _____ SOCIAL SECURITY # OR UNIQUE ID # _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE _____

NATURE OF DISABILITY: _____

DATE ACCIDENT OCCURRED OR SICKNESS BEGAN: _____

IF DISABILITY WAS DUE TO AN INJURY PLEASE ADVISE HOW, WHEN AND WHERE THE INJURY OCCURRED: _____

_____

WAS INJURY OR SICKNESS CAUSED BY ANY EMPLOYMENT? _____

HAS THERE BEEN, OR WILL THERE BE, A CLAIM FILES FOR THIS DISABILITY WITH A WORKER'S COMPENSATION CARRIER? _____

LAST DATE WORKED: _____ DATE EXPECTED TO RETURN TO WORK: _____

SIGNATURE _____ DATE _____

PORTION BELOW TO BE COMPLETED BY ATTENDING PHYSICIAN

NATURE OF SICKNESS OR INJURY: _____

DATE FIRST TREATED FOR THIS CONDITION: _____

DATE OF MOST RECENT TREATMENT: _____

THE PATIENT HAS BEEN CONTINUOUSLY DISABLED (UNABLE TO WORK) FROM _____ THROUGH _____

WHEN SHOULD THE PATIENT BE ABLE TO RETURN TO WORK? _____

IF STILL DISABLED, WHEN WILL THE PATIENT BE RE-EVALUATED FOR RETURN TO WORK? _____ (NEXT APPOINTMENT)

REMARKS: _____

ADDRESS _____ PHONE# _____

PHYSICIAN'S SIGNATURE _____ DATE: _____

PHYSICIAN'S NAME (PRINT) _____ DEGREE _____