DISABILITY PROOF OF CLAIM AND PHYSICIAN'S STATEMENT

Zenith American Solutions
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INSTRUCTIONS:

1. Complete Section I and either Section II (work related) or Section III (nonwork related).
2. Have your physician complete Section IV and submit the completed form to the Medical Fund.
3. If injury is work related, submit copy of worker's compensation award and dates of payments (i.e., check copies).

SECTION I (To be completed by Employee – Please Print or Type)	
1. Name of Employee Local No.	5. Employer
2. Employee's Address	6. Employer Address
3. Home Telephone No.	7. Employer Telephone No.
4. Social Security No.	8. Employee Date of Birth

SECTION II (Complete this section only if injury or illness occurred on the job)

9. Date of injury _____, 20___ Day of Week_____ Hour of day_____ A.M. _____P.M.
10. Date disability began _____, 20___ _____A.M. _____P.M. Were you paid in full for this day?_____
11. When did you or foreman first know of injury?_____
12. Name of foreman_____
13. Describe fully how accident occurred, and state what employee was doing when injured._____
    _____
    _____
14. Last day worked_____ Job Site:_____

15. Name and address of physician who first treated you	16. If hospitalized, give name and address of hospital

SECTION III (Complete for non-job related injury or illness)

17. Nature of illness or injury	18. Last Day Worked

19. If accident (Describe)

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 of knowledge of me or y health to give any such information to the **HEALTH FUND**. A photo 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 IV (To be completed by attending physician)

1. Diagnosis and concurrent conditions (if diagnosis code other than ICDA used, give name):

2. Date symptoms first appeared or accident happened.	3. Date patient first consulted your 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	SSN	Telephone

Street Address	City or Town	State	Zip Code