PIPE FITTERS LOCAL UNION NO. 211 WELFARE TRUST FUND

P. O. Box 87549 - Houston, Texas 77287
Toll Free (866) 236-3148 (713) 643-9300 - FAX (866) 316-4794
www.benefitresourcesinc.com

PARTICIPANTS STATEMENT

NO HOURS CAN BE CREDITED UNTIL THIS FORM IS COMPLETED BY YOU AND THE ATTENDING PHYSICIAN AND IS RETURNED TO THIS OFFICE

NOTE: **YOU MUST BE COVERED FOR INSURANCE AT THE TIME OF DISABILITY**

Participant's Name ______________________ Participant's Social Security Number ______________________

Street Address ______________________ City ____________ State ______ Zip ______

Nature of sickness or injury ______________________________

Is this claim based on an accident? ☐ Yes ☐ No
If yes, give date of accident ____________
Where did accident occur? ______________________________
How did accident occur? ______________________________
Are any of the illnesses or injuries for which claim is being made related to employment? ☐Yes ☐ No

NOTICE: **YOU ARE NOT ENTITLED TO DISABILITY HOUR UPON RETIREMENT ANY HOURS POSTED IN ERROR AFTER RETIREMENT WILL BE REMOVED WHICH MAY RESULT IN LOSS OF ELIGIBILTY**

Participant's Signature ______________________ Date ______________________

ATTENDING PHYSICIAN'S STATEMENT

Date pf first visit: __________

Frequency of Treatment: ____________________

This patient has been continuously disabled (unable to work) from __________through __________

If still disable, when should patient be able to return to work ______________________

Remarks: ______________________________
____

Signature of Attending Physician ______________________ Date ______________________

Address ______ City, State Zip ______ Telephone Number ______________________