SHORT-TERM DISABILITY CLAIM FORM

AFL-AGC BUILDING TRADES WELFARE & PENSION PLANS

Important Notice to Employee – Please Read Carefully

You or someone acting on your behalf should complete Section 1 and then have your physician complete Section 2. Submit the form to us at the address or fax number listed below. All claims must be filed within 90 days of the date you become disabled. Disability benefits are payable as often as weekly; however, the plan will not pay ahead (i.e. the plan will not pay your claim beyond the date the doctor signs the form). If you prefer, you may file a single claim form to collect one (1) lump sum payment for the entire disability period, once your doctor has released you. If you are filing for the Maternity Leave benefit, only one claim form is required. Once approved, you will receive the weekly payment for the duration of your maternity leave.

SECTION 1: TO BE COMPLETED BY THE EMPLOYEE

Employee Full Name:	Employee Phone Number:	Social Security Number:	Birthdate: (mm/dd/yyyy)

Employee Street Address	City:	State:	Zip Code:

Disability is due to:

- ☐ Accident (Non-Occupational) Date of Accident: ____ /____ /_____
- ☐ Illness
- ☐ Planned Surgery
- ☐ Maternity Leave

If your disability period results from an accidental bodily injury, your Disability Benefit begins on the first work day lost. If your disability period results from an illness or planned surgery, the disability benefit begins on the eighth day after you become disabled.

The Maternity Benefit is available to any Active Employee, Owner Member, or Non-Bargaining Unit Employee who is pregnant and leaves employment in connection with the birth of a child. The weekly disability benefit amount is payable for six (6) weeks for a traditional delivery and eight (8) weeks for a Cesarian section delivery for any such eligible employee who does not work during that period of time. The benefit shall begin two weeks before the expected delivery date unless the participant's physician certifies that the participant is unable to work because of pregnancy before that date.

Employee Signature:	Date: (mm/dd/yyyy)

SECTION 2: TO BE COMPLETED BY THE PHYSICIAN

Patient Name:	Diagnosis:

Is the disability due to pregnancy? ☐ Yes ☐ No

If yes, expected due date (mm/dd/yyyy): _____ / _____ / _____ Type of delivery ☐ Traditional ☐ C-section

Is the disability due to a non-occupational accident? ☐ Yes ☐ No

If yes, date first treated (mm/dd/yyyy): _____ / _____ / _____ This patient is totally disabled through (mm/dd/yyyy): _____ / _____ / _____

Is the disability due to a planned surgery? ☐ Yes ☐ No

If yes, date of operation (mm/dd/yyyy): _____ / _____ / _____ This patient is totally disabled through (mm/dd/yyyy): _____ / _____ / _____

Is the disability due to an illness? ☐ Yes ☐ No

If Yes, Date first treated (mm/dd/yyyy): _____ / _____ / _____ This patient is totally disabled through (mm/dd/yyyy): _____ / _____ / _____

Is the paitent totally disabled at present time? ☐ Yes ☐ No	Remarks:

Physician Name:	Physician Phone Number:

Physician Street Address:	Physician City:	Physician State:	Physician Zip:

Physician Signature:	Date: (mm/dd/yyyy)

Fax Completed form to
(251) 432-0590
Or
Mail completed form to
P.O. Box 1492
Mobile, AL 36633