WEST VIRGINIA LABORERS TRUST FUND

DISABILITY CLAIM FORM

PLAN OFFICE

WEST VIRGINIA LABORERS
TRUST FUND
ONE UNION SQUARE
SUITE 200
CHARLESTON, WV 25302

Phone: (304) 342-5142
Fax: (304) 342-2610

Section I: Participant Information

Name: _____ Soc. Sec. No: _____

Address: _____ Birth Date: _____

City: _____ State: _____ Zip Code: _____ Telephone: _____

Local Union No: _____ Date of last employment: _____ Last employer: _____

Section II: Participant Statement

Complete this section only if you are filing a claim for Accidental Death Benefits.

Date of Accident: _____ Location of Accident: _____

Did the accident arise out of or occur in the course of employment? ___ YES ___ NO

Describe how the accident occurred and the nature of the injuries (include attachments if more space needed):

On what date were you treated by a physician?_____

Have you returned to work?_____ If so, on what date? _____

Are you totally disabled by the sickness or injury? ___ YES ___ NO

Describe complications and/or limitations you have due to the injury or illness:

Date:_____ Participant Signature: _____

Section III: Attending Physician's Statement

Patient's name_____

Nature of ☐ Sickness or ☐ Injury? ICD Code Number_____

Describe the injury/sickness and patient's complications:

Is the injurt/sickness work related?___ YES ___ NO

Date of first treatment_____ Date of most recent treatment _____ Frequency of Treatments_____

The patient has been continuously disabled (unable to work) from _____(date) and should be able to return to work on _____ (date) (provide approximate dates if necessary)

Physician Name: _____ Date: _____ Phone Number: _____

Physician Signature: _____ Physician full address: _____

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