Los Angeles Machinist Benefit Trust

3333 Vincent Rd., Suite 203-A • Pleasant Hill, CA 94523 • Phone (800) 499-8121 • Fax (925) 405-0659

TO BE COMPLETED BY EMPLOYEE

NO	YES	
☐	☐	IS THIS DISABILITY DUE TO OCCUPATIONAL CAUSE OR CAUSES?
☐	☐	HAS A CLAIM BEEN FILED FOR WORKER'S COMPENSATION?
☐	☐	WILL SUCH A CLAIM BE FILED?

☐ Male ☐ Female

_____
Please print last name First Middle

_____
Home address

_____
City-State-Zip Code Home phone number

_____ _____
Date of birth Social Security Number

_____
Name of employer (firm name)

_____ _____
Occupation Local Union Number

_____ at _____ _____
First date you were unable to work time (am-pm) Employer's Phone #

DESCRIBE DISABILITY: _____

_____

_____

_____

WE NEED THIS SECTION COMPLETED IN ORDER TO FURTHER CONSIDER YOUR CLAIM.

PLEASE ALSO SIGN THE AUTHORIZATION TO RELEASE INFORMATION ON REVERSE SIDE OF FORM.

_____
Claim Number

All answers are true and correct to the best of my knowledge.

_____ _____
Employee's signature Date signed

EBDD Statement of Claim for Time Loss Benefits lw 11.14.13

COMPLETE ONLY IF ACCIDENT INVOLVED

_____ _____ _____
Date of accident Time (am-pm) Where did accident occur?

DESCRIBE THE ACCIDENT FULLY:

THE ATTENDING PHYSICIAN MUST COMPLETE THE REVERSE SIDE OF THIS FORM

HEALTH CLAIM—GROUP DISABILITY INCOME

PART A TO BE COMPLETED BY PATIENT (MEMBER)

AUTHORIZATION FOR RELEASE OF INFORMATION
GROUP HEALTH BENEFITS

I AUTHORIZE any physician, medical practitioner, hospital, Veterans Administration Hospital, clinic, other medical or medically related facility, insurance company, consumer reporting agency, employer or group policy holder having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give to East Bay Drayage Drivers Security Fund (hereinafter called The Fund) or its legal representative, any and all such information.

I UNDERSTAND the information obtained by use of the Authorization will be used by The Fund or its authorized claims paying administrator to determine eligibility for benefits or services under a policy. Any information obtained will not be released by The Fund to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., employer, group policyholder, contract holder, or other persons or organizations performing business or legal services in connection with my claim or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request to receive a copy of the Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE this Authorization shall be valid for two and one-half years from the date shown.

I UNDERSTAND that it is my responsibility to update the Administration office if my return to work date is extended beyond the return to work date noted on this form.

PATIENT'S SIGNATURE (if other than a minor child) X _____	MEMBER'S SIGNATURE X _____ DATE _____	*I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAL OR SUPPLIER FOR SERVICE DESCRIBED BELOW.* *SIGNED (Member or Authorized Person)* *X* _____

PART B ATTENDING PHYSICIAN'S STATEMENT

1. DIAGNOSIS AND CONCURRENT CONDITIONS (If diagnosis code other than ICD9* used, give name.)	
2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? No ☐ Yes ☐ PREGNANCY? No ☐ Yes ☐ EDC _____	
3. DATES OF SERVICES (If previous form submitted to this carrier, you need show only dates since last report.)	
4. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED	5. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION
6. PATIENT EVER HAD SAME OR SIMILAR CONDITION? (If yes, state when and describe.) No ☐ Yes ☐	7. PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? No ☐ Yes ☐
8. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (unable to work) FROM THRU	9. PATIENT WAS PARTIALLY DISABLED FROM THRU
10. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK.	11. PATIENT WAS HOUSE CONFINED FROM THRU
12. HOSPITALIZATION DATES ADMITTED DISCHARGED	13. DOES PATIENT HAVE OTHER HEALTH COVERAGE? (If yes, identify.) No ☐ Yes ☐
DATE PHYSICIAN'S NAME (PRINT) SIGNATURE DEGREE TELEPHONE	
STREET ADDRESS CITY STATE ZIP CODE	

*ICD9—International Classification of Diseases

INDIVIDUAL PRACTITIONERS S.S. NO (Must be furnished under authority of law.) _____ _____ _____

ALL OTHERS—EMPLOYER I. D. NO. _____ _____