125 Barclay St., New York, N.Y. 10007-2179 • Telephone: (212) 815-1300

DC 37 Health & Security Plan

Dear Member:

Disability claim forms received by our office are frequently delayed or returned to the member because they are incomplete. Your Claim May Be Delayed Or Returned Unless You Do The Following:

- Sign your claim.
- Give the phone number of your timekeeper/payroll/personnel department.
- Describe your illness.
- If you were involved in an accident, indicate how, when and where you were injured.
- Indicate if there is a lawsuit - if so, indicate the Attorney's name, address and telephone number.
- Make certain your social security number is correct.
- Enclose a copy of your Marriage/Divorce/Separation papers if you have changed your name.
- Attach an explanation to your claim if it is filed 15 or more days after the onset of your disability.
- Make sure you have a DC 37 Health & Security Plan Enrollment Card on file.

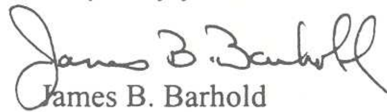
The "Physician's Statement" section of the claim form is to be entirely completed and only by a licensed medical doctor.

You should not complete or alter any of the information in this section. Check particularly to be sure that your doctor includes dates of all treatments and expected duration of your disability.

If you leave your claim form with your physician, have him/her return the claim to you. This is recommended so you can review the form to ensure that it is completed properly before submitting it to the Plan office for processing.

Thank you for reading this and filling out your claim carefully.

Very truly yours,



James B. Barhold
Manager - Disability Unit

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(REV:6/2000)

ROSLYN YASSER, *ADMINISTRATOR*, **ELIOT A. SEIDE**, *CHAIRMAN*, **MARLENE ROSENBERG**, *VICE CHAIRWOMAN*
TRUSTEES: **DOROTHY BROWN, JAMES PARKER, DENNIS SULLIVAN, MAGDA DE JESUS, JOHN TOWNSEND**
Established by District Council 37, American Federation of State, County & Municipal Employees, AFL-CIO X23

DISTRICT COUNCIL 37 HEALTH & SECURITY PLAN

125 BARCLAY STREET, NEW YORK, N.Y. 10007

HS:DIS 013

Please Type or Print

SHORT-TERM DISABILITY BENEFIT CLAIM

Phone: (212) 815-1234

TO BE FULLY COMPLETED BY EMPLOYEE AND FILED WITHIN 15 DAYS FROM THE DAY YOU BECOME DISABLED REGARDLESS OF SICK, VACATION OR ANNUAL TIME.

EMPLOYEE INFORMATION

Name ______________________ Soc. Sec. No. ______________

Home Address ____

No. & Street City State Zip

Date of Birth ______________ Male ☐ Female ☐ Home Phone ______________

JOB INFORMATION

Name of your work place ______________________ Date of Employment ______________

Work Address ______________________ Timekeeper Personnel Phone No. ______________

Department ______________________ Payroll

Job Title ______________________ If school worker, District Office No. ______________

Annual Salary ______________________ Hours worked per day ______________

How many sick days did you have on the date you become disabled? ______________

ILLNESS INFORMATION

When did you become totally disabled so that you could not work? Date: ______________

What date did you first see a doctor? ______________ Name of doctor ______________

Describe your illness ____

Have you returned to work yet? Yes ☐ No ☐ If yes, what date? ______________

Have you ever received disability payments for the same illness? Yes ☐ No ☐ If yes, what year? ______________

IF CONFINED IN HOSPITAL

Name of Hospital ____

Address of Hospital ____

Date Admitted ______________ ☐ AM ☐ PM Date Discharged ______________

IF DISABILITY IS DUE TO ACCIDENT

A. Date of accident ______________ ☐ AM ☐ PM B. How did it happen? ______________

____

C. Did it happen at work? Yes ☐ No ☐ D. Did you file for Workers' Compensation? Yes ☐ No ☐

E. Is there a lawsuit? Yes ☐ No ☐

F. If yes, give attorney's name ____

Address ______________________ Phone No. ______________

SIGN HERE

The above statements are true and complete to the best of my knowledge and belief and I hereby authorize any hospital or physician who has treated me to furnish any and all medical information to District Council 37 Health and Security Plan.

Signature ______________________ Date ______________

(SIGNATURE ONLY—DO NOT PRINT)

IF YOU ARE PLANNING TO GO OUT OF THE NEW YORK AREA AFTER YOU HAVE APPLIED FOR DISABILITY BENEFITS, YOU MUST CONTACT THE HEALTH & SECURITY PLAN OFFICE OR YOUR CLAIM WILL BE DECLARED INELIGIBLE.

DISTRICT COUNCIL 37 HEALTH & SECURITY PLAN

125 BARCLAY STREET, NEW YORK, N.Y. 10007

(212) 815-1234

ATTENDING PHYSICIAN'S STATEMENT

Patient__________ **Claim No.**__________ **Age**_____ **Sex**_____

DIAGNOSTIC CATEGORY

A. Medical Conditions/Diagnosis

(IMPORTANT: **THIS CLAIM CANNOT BE PROCESSED WITHOUT THE APPROPRIATE ICD CODES.)**

	ICD CODE	DESCRIPTION
Primary Diagnosis	___.___	__________
Secondary Diagnosis	___.___	__________
	___.___	__________

Is patient's disability related to Substance Abuse YES ☐ NO ☐ and/or Alcoholism YES ☐ NO ☐

Is patient's disability related to an accident? YES ☐ NO ☐

Is patient's disability a result of an injury arising out of and in the course of employment or an occupational disease? YES ☐ NO ☐

TREATMENT INFORMATION

B. Specific Dates of Treatment for this Illness: _____; _____; _____; _____; _____

If hospitalized for this disability: Date Admitted__________ Date Discharged__________

Name of Hospital:__________ Address:__________

If surgery was performed, give the date(s): __________

Type of Surgery: *(with CPT code)*__________

If pregnancy, list date, or expected Date of Delivery: __________

Type of delivery: Normal ☐ C-Section ☐

Are there other disabling conditions accompanying this pregnancy? YES ☐ NO ☐

If yes, please list::__________

C. Therapy

Is patient receiving Chemotherapy, Radiation or on Dialysis? YES ☐ NO ☐

If yes, give dates: ____; ____; ____; ____; ____; ____; ____; ____

Is patient receiving Physical Therapy? YES ☐ NO ☐

If yes, give dates: ____; ____; ____; ____; ____; ____; ____; ____

Is patient in a program for Substance Abuse? YES ☐ NO ☐

Name of Program__________ Telephone Number__________

Dates in attendance: ____; ____; ____; ____; ____; ____; ____; ____

D. Anticipated Duration For This Disability

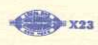
(Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)

Patient's disability is expected to extend from__________ through.__________

SIGN HERE

__________	__________	__________
Physician's Signature	Name (Print)	Degree Specification
Licensed in the State of	License Number	
Address	Phone	Date

REV:5/98



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