STATEMENT OF CLAIM
FOR
ACCIDENT AND SICKNESS
WEEKLY BENEFITS

TRUST FUND OFFICE
445 APPLE STREET – P.O. BOX 11337
RENO, NV 89510
Phone (775) 826-7200
Fax (775) 826-3872 or (775) 826-7289

TO BE COMPLETED BY THE EMPLOYEE

(Please answer all questions) Union Local #_____

1. Employee's name (Print)_____ Phone_____ (Include Area Code)
2. Present address: No._____ Street_____ City_____ State_____ Zip Code_____
   Employee's description: ☐ Male ☐ Female Age_____ ☐ Single ☐ Married
3. Date you were first disabled by this sickness or injury _____ (month/day/year)
4. Are you still disabled? ☐ Yes ☐ No If not, when did you recover?
5. Was an accident involved? ☐ Yes ☐ No If "Yes," answer the following:

   (a) When did the accident happen? Date _____ (month/day/year) at _____ (Hour) a.m./p.m.

   (b) Where did the accident happen? Location _____ City _____ State _____

   (c) Were you at work when the accident happened? ☐ Yes ☐ No

   (d) Give a brief description of the accident _____

_____

I hereby authorize the Physician to release any information requested with respect to this Claim.
I certify that the information furnished by me in support of this claim is true and correct.

_____
Social Security No.

Date_____ Signed *(Insured Employee)* _____

TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Patient's name_____ Age _____

Nature of sickness or injury (Describe complications, if any) _____

_____

_____

Date of first treatment _____ (month/day/year)

Date of most recent treatment _____ (month/day/year)

Frequency of treatments _____

The patient has been continuously disabled (unable to work) from _____ through _____

If still disabled, when should patient be able to return to work? _____

Remarks: _____

_____

Signed _____
(Attending Physician)

Print Name _____

Address _____

_____

Date _____ (month/day/year)

Phone _____