Northern Minnesota-Wisconsin Area Retail Food Health & Welfare Fund

SHORT TERM DISABILITY CLAIM FORM

Group Number: **5WM00400**

This form **MUST** be completed to be considered for Short Term Disability benefits.

Return completed forms to:
Wilson-McShane Corporation, Attn: Claims Department,
2002 London Road, Suite 300, Duluth, MN 55812
Phone: 218-728-4231, Toll Free: 800-570-1012, Fax: 218-728-4773

PART A: *TO BE COMPLETED BY PATIENT (INSURED)*

1. Personal Information

Your Name: ____________________

Social Security Number / ID#: ____________________

Phone #: ____________________

Date of Birth: ____________________

Address: ____________________

____

2. Authorization to release information:

I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment. I also make claim for benefits and certify that the statements under Part A are true and complete to the best of my knowledge.

____________________ Signature of Insured ____________ Date

3. State last day worked because of disability:

______ / ______ / ______
month day year

4. On what date were or will you be able to return to work:

______ / ______ / ______
month day year

5. If injured, how and where did the accident occur?

6. Did injury occur in the course of employment?

❑ Yes ❑ No

7. Have you or do you intend to file this claim under Workmen's Compensation?

❑ Yes ❑ No

8. Are you now engaged in the duties of any occupation or endeavor for wages, profits or compensation?

❑ Yes ❑ No

9. Did injury occur as the result of an auto accident?

❑ Yes ❑ No

10. Did injury occur as the result of another party?

❑ Yes ❑ No

PART B: *ATTENDING PHYSICIAN'S STATEMENT*

11. Diagnosis and concurrent conditions:

12. Frequency of visits:

❑ Weekly ❑ Monthly ❑ Other:____________________

13. Is patient totally disabled from his/her regular occupation?

❑ Yes ❑ No

Date patient became totally disabled: ______ / ______ / ______
month day year

14. On what date will patient be able to resume normal activities and return to work?

______ / ______ / ______
month day year

15. Attending Physician's Information

Physician's Name: ____________________

Physician's Signature: ____________________

Phone #: ____________________

Degree: ____________ Date: ____________

Address: ____________________

____

16. Remarks:

____

____

____

____

____

PART C: *TO BE COMPLETED BY EMPLOYER*

17. Gross weekly earnings: $____________

18. First full day unable to work: ______ / ______ / ______
month day year

19. Resumed work: ______ / ______ / ______
month day year

20. Expected to resume work: ______ / ______ / ______
month day year

21. Terminated: ______ / ______ / ______
month day year

22. Did injury occur in the course of employment? ❑ Yes ❑ No

Employer telephone #: ____________________

21. Employer signature ____________________ Title: ____________ Date : ______ / ______ / ______
month day year