Form CL-1 REV 06/14

DISABILITY CLAIM FORM

UNITED TRANSPORTATION UNION INSURANCE ASSOCIATION

A FRATERNAL BENEFIT SOCIETY

24950 COUNTRY CLUB BLVD., STE 340 NORTH OLMSTED, OHIO 44070-5333

TELEPHONE (216) 228-9400 FAX (216) 228-0411

The furnishing of this blank shall not be held to be a waiver of any conditions of your policy.

POLICYHOLDER'S NAME, ADDRESS, AND LOCAL NUMBER (please print)

Policy Number(s) you are claiming on:

____

____

____

____

INSTRUCTIONS ON COMPLETING THIS CLAIM FORM

1. COMPLETE, SIGN AND DATE THIS FORM. THEN HAVE YOUR DOCTOR AND TREASURER COMPLETE THEIR PORTION OF THE CLAIM FORM.
2. BENEFIT PAYMENTS ARE MADE ON A MONTHLY BASIS. IN ORDER TO RECEIVE A FULL MONTH'S BENEFIT, PLEASE COMPLETE THIS CLAIM FORM 30 DAYS AFTER YOUR ELIMINATION PERIOD HAS ENDED.
3. CLAIMS BEGIN FROM THE DATE OF THE FIRST MEDICAL ATTENTION AFTER YOUR LAST DAY WORKED.

Please indicate whether this claim is for an ____ **injury** or ____ **illness**? **(check the one that applies)**

If claim is for an injury, please name injury and furnish details of when, where, and in what manner it occurred.

____

____

____

If claim is for an illness, please name illness and date symptoms first appeared. ____________________

____

List names and addresses of all Physician's treating you for this illness or injury:____________________

____

List all dates of medical treatments. ____________________

If hospitalized, please list name of Hospital: ____________________

City: ____________________ State:____________________

Admitted: ____________________ Discharged: ____________________

What was the last day you worked prior to your disability?____________________

What was your occupation at the time of your disability? ____________________

*Employer's Name/Address/ Telephone Number:*____________________

Have you resumed any work? ____________________ ***If yes, please give date(s):*** ____________________

Have you accepted light duty? ____________________ ***If yes, please give date(s):*** ____________________

*If you work on the railroad, did you accept the RAILROAD WAGE CONTINUATION PROGRAM? (yes/no)*____________________

If yes, please give date you accepted RWCP: ____________________ *Date you went off RWCP:* ____________________

Your cooperation in completing this claim form in its entirety by all responsible parties will permit the prompt handling of your claim and avoid any unnecessary delays.

I hereby authorize any licensed physician, medical practitioner, clinic, hospital or other medically related facility, insurance company, or other person, organization or institution, that has any records or knowledge of me, to give United Transportation Union Insurance Association or its representative, any such information.

A photocopy of this authorization shall be as valid as the original.

Date: ____________________ **Insured's Signature:** ____________________

Mailing Address (Street, City, State, Zip): ____________________

Social Security No: ____________________ **Telephone No.** ____________________ **Cell No.** ____________________

(Required for Payment)

ATTENDING PHYSICIAN'S STATEMENT

ANY EXPENSE INCURRED IN THE FURNISHING OF THIS REPORT IS TO BE BORNE BY THE CLAIMANT.

Patient's Name: ____**Age:** ______________

Medical Diagnosis:	**ICD Code:**

On what date did symptoms of this illness first appear or accident happen? ___________________________

On what date did patient first consult you for this condition? _____________________________________

Has patient ever been diagnosed or treated for the same or similar condition? ______________________

If yes, state when and describe: ____

____

Please indicate and describe any surgical procedure performed. ____________________________________

____

Give dates of treatment. ____

Have you discharged patient? __________ If yes, give date: _______________

Was patient hospitalized as an inpatient as a result of this diagnosis? ___________
If yes, please give name and dates of hospital confinement:

Hospital: ____

City: ___________________________ State: ___________________________

Admitted: _______________________ Discharged: _____________________

How long will this diagnosis render the patient unable to perform their regular job?

From Date: _______________________ **To Date:** _________________________
MONTH DAY YEAR MONTH DAY YEAR

Additional Remarks: ____

Physician's Name (PRINT): ____________________________ **Signature:** ____________________________ **Degree:** ______

Address: ____**City:** ________________________ **State:** ______

Zip: _________ **Telephone No. (   )** ____________________ **SS# or TIN:** ________________ **Date:** ______________

******TREASURER'S STATEMENT******

Do you know if this disability is as stated? Yes/No __________

What was the last day the insured stopped working due to this disability? _________________________

Has the Insured returned to work? ____________________ *If yes, please give date:* ______________________

Has the insured accepted a light duty assignment? yes/no ______ *from date:* ______________ *to date:* ______________

Date:__________________________ ***Treasurer's Signature:*** ______________________________ ***Local:*** __________

FRAUD WARNING

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (O.R.C. -Sec.3999.21)

For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.