

J.W. TERRILL  
 825 MARYVILLE CENTRE., DR. STE 200  
 CHESTERFIELD, MO 63017  
 PHONE (314) 594-2755  
 FAX (314) 594-2472

## DISABILITY CLAIM FORM

<b>PART 1: MUST BE COMPLETED BY PARTICIPANT</b>			
PARTICIPANT NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	HOME PHONE #
HOME ADDRESS	CITY	STATE	ZIP CODE
NAME OF EMPLOYER	EMPLOYER PHONE #	JOB TITLE	
WAS THIS DISABILITY WORK RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, HAVE YOU FILED WITH YOUR EMPLOYER? <input type="checkbox"/> YES <input type="checkbox"/> NO			
I WAS FIRST TREATED BY DR. _____ ON _____ <small style="display: inline-block; width: 150px; text-align: center;">DOCTOR NAME</small> <small style="display: inline-block; width: 150px; text-align: center;">DATE OF VISIT</small>			
THE DATE OF MY LAST DOCTOR VISIT WAS ON _____ WITH DR. _____.			
<b>CERTIFICATION AND AUTHORIZATION TO RELEASE INFORMATION:</b> <small>I hereby certify that the above information is true and correct to the best of my knowledge. I understand that a falsification or withholding of material facts may result in loss of benefits. For the purpose of determining eligibility for benefits and claim processing, I hereby authorize St. Louis Graphic Arts Joint Health &amp; Welfare Fund to receive from and/ or provide to medical practitioners, medically related facilities, insurance companies or like organizations or my employers, information as to physical or mental condition of myself or my covered dependents. I know that I have a right to receive a copy of this authorization. I agree a photographic copy is as valid as the original.</small>			
X _____ <small>PARTICIPANT SIGNATURE</small>		X _____ <small>DATE</small>	

<b>PART 2: TO BE COMPLETED BY PHYSICIAN</b>			
PATIENT'S NAME	DATE OF FIRST VISIT FOR CURRENT CONDITION		
DIAGNOSIS AND CONCURRENT CONDITIONS			
Is sickness or accident related to patient's employment? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, Please Explain _____			
Date patient first consulted you for this condition?		Expected date of delivery?	
Was surgery performed? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, give date and type of surgery done _____			
Considering the claimant's occupation, could claimant resume duties of his usual and customary work while continuing treatment? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, please explain why _____			
Is patient still under your care? <input type="checkbox"/> YES <input type="checkbox"/> NO Last Visit _____ Next Appointment _____			
Patient was continuously disabled (unable to work) from _____ to _____			
If off longer than the normal length of disability for this condition please list complications _____			
The patient recovered, or will recover, sufficiently to return to his regular job on _____			
Dates of hospitalization from _____ to _____ Hospital Name _____			
ATTENDING PHYSICIAN'S PRINTED NAME		TAX IDENTIFICATION NUMBER	
STREET ADDRESS		( ) _____ PHONE NUMBER	( ) _____ FAX NUMBER
CITY	STATE	ATTENDING PHYSICIAN SIGNATURE	
		ZIP	

<b>PART 3: TO BE COMPLETED BY FUND OFFICE ONLY</b>			
Weekly Salary _____	Last Day Worked _____	Returned to Work _____	Hrs in Work Week _____
Whom Contacted _____		Date _____ Signed: _____	
NOTES: _____			