INTERNATIONAL UNION OF OPERATING ENGINEERS
LOCALS 181, 320, AND TVA
HEALTH AND WELFARE TRUST
700 North Elm Street • P.O. Box 1179
Henderson, Kentucky 42419-1179
Phone 270-826-6750 • Fax 270-826-6770

For disability hours to be considered, you must submit the completed form to our office. If you qualify, the Fund can credit you for up to 10 weeks of disability hours. These hours will be credited to help give you coverage for your health insurance at a time when you are unable to work. These hours are determined by the amount of time your physician states you were unable to work. Please complete the top section of the form and have your physician, physician's office or nurse complete the Attending Physician's Statement, then have the physician sign and date the form at the bottom.

*****Please note: the Attending Physician must enter a "thru" date on the form. It cannot be a future date, open-ended, or undetermined. **Don't have your physician fill out their part until you go back to work or have been off at least 10 weeks, whichever comes first.**

If you have any questions, please feel free to contact our office.

Sincerely,

IUOE Local 181, 320 and TVA
Health & Welfare Fund Office

Email: chelsea.jones@iuoe181hw.org

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Health Insurance Disability Claim Form

Applicant Information

Member's Name: _____ Date of Birth: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Social Security # : _____ Phone No.: _____

AUTHORIZATION TO RELEASE INFORMATION: *I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment.*

Member's Signature: _____ Date: _____

Attending Physician's Statement

TO BE COMPLETED BY ATTENDING PHYSICIAN: *The following information is needed to document the patient's inability to work. The patient is responsible for obtaining a complete form without expense to the Health & Welfare Fund.*

Diagnosis: _____ ICDA Classification: _____

Patient was continuously totally disabled (unable to work): From: _____ Thru: _____

PHYSICIAN INFORMATION: *Please type or print.*

Name of Physician: _____ Specialty: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Phone No.: _____

Physician's Signature: _____ Date: _____

****Phone: 270-826-6750 ~ Send form to: healthandwelfare@iuoe181hw.org or fax to: 270-826-6770****