Colorado Finishing Trades Health and Welfare Fund

2821 South Parker Road
Suite 215
Aurora, Colorado 80014
Phone: (303)745-1941

DISABILITY CLAIM FORM

EMPLOYEE INFORMATION

EMPLOYEE'S NAME ____________ DATE OF BIRTH ____________ Social Security # ____________

COMPLETE HOME ADDRESS ____________ CITY ____________ STATE ____________ ZIP ____________

____________ DATE(S) CALLED IN SICK ____________

TELEPHONE NUMBER INCLUDING AREA CODE ____________

TYPE OF DISABILITY

ARE YOU STILL DISABLED? ☐YES ☐NO WAS CONDITION RELATED TO: ☐PATIENT'S EMPLOYMENT ☐AN ACCIDENT

IF CONDITION WAS RELATED TO AN ACCIDENT PLEASE EXPLAIN: ____________

DATE: ____________ TIME: ____________

BRIEF DESCRIPTION: ____________

HAVE YOU RECEIVED ANY WORKER'S COMPENSATION IN CONNECTION TO THIS DISABILITY? ☐YES ☐NO

HAVE YOU FILED ANY CLAIM(S) FOR WORKER'S COMPENSATION INSURANCE BENEFITS DURING ANY PERIODS FOR WHICH YOU HAVE CLAIMED DISABILITY BENEFITS? ☐YES ☐NO

I hereby certify that the foregoing statements, including any accompanying statements, are true, correct and complete to the best of my knowledge and hereby further authorize my attending physician, practitioner or hospital in which confinement took place to furnish and disclose all facts concerning my physical condition that are within their knowledge. I agree that if I receive Worker's Compensation benefits in connection with this injury or illness, I will repay the Trust for any duplicate payments that I receive. Any duplicate payments owed to the trusts may be first deducted from any Worker's Compensation benefits payable to me by the District or, if there are no such benefits payable, will be repaid by me.

____________ Date ____________ Signature of Employee

PHYSICIAN CERTIFICATION

PATIENT'S NAME ____________ AGE ____________

Describe complications if any
NATURE OF SICKNESS ____________

DATE OF MOST RECENT TREATMENT ____________ DATES OF HOSPITALIZATION FROM ____________ THROUGH ____________

THE PATIENT HAS BEEN CONTINUOUSLY DISABLED (unable to work) FROM ____________ THROUGH ____________

REMARKS: ____________

I hereby approve release of information pertaining to hospital confinement of this patient to Colorado Finishing Trades Health Benefit Fund on authorization of the insured.

DATE ____________ PHYSICIAN'S NAME/ SIGNATURE ____________ FED. TAX ID NO/ SS# ____________ TELEPHONE NUMBER ____________

ADDRESS: ____________