SERVICE EMPLOYEES BENEFIT FUND

P.O. Box 1240
Syracuse, NY 13201
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WEEKLY DISABILITY CLAIM FORM

This form is to be used for NON-WORK related illness or injury

1. Be sure to **sign and date the claim form (Item #10)**
2. Complete all items in **PART A –CLAIMANT STATEMENT**. Please be accurate and check all dates;
3. Have your **Physician** complete and sign **PART B – Physicians Statement.**
4. Have your **Employer** complete and sign **PART C –Employers Statement**; and
5. Mail or Fax the completed claim form within 30 days after you become disabled to the above address or fax.

PART A – CLAIMANT'S STATEMENT - To **Be Completed By Employee** (Please print)

1. Name _____ 2. Birth Date _____
First Middle Last

3. Address _____
Number Street Apt. # City/Town State Zip Code

4. Social Security No. _____ 5. Tel. No. (____) _____

6. My Disability is (If injury, also state **how**, **when** and **where** injury occurred): _____

_____

7. Date I became disabled _____ a) I worked on that date ( ) Yes ( ) No
Date

b) I have since worked for wages or profit ( ) Yes ( ) No If "Yes", give dates: _____

8. I am a ( ) Full-Time ( ) Part-Time employee (please choose one).

9. Employer's Name _____

a) Address _____
Number Street City/Town State Zip Code

b) Employment Dates: **From** _____ **To** _____
Month Day Year Month Day Year

10. I read the instructions above. I claim Weekly Disability Benefits and certify that I was disabled for the period covered by this claim and that the foregoing statements (and any accompanying statements) are true, complete and accurate.

I agree to notify SEBF of my return to work date in a timely manner. I understand that I will be responsible for reimbursing SEBF for any overpayment made for days paid after I have been released to return to work.

Signature _____ **Date** _____
Claimant's Signature

If signed by anyone other than Claimant, print below:

_____
Name Address Relationship

Your Physician Must Complete Part B and Your Employer Must Complete Part C on the Back of This Form ▸

Service Employees Benefit Fund
Weekly Disability Claim Form

PART B – PHYSICIAN'S STATEMENT – To Be Completed By Physician (Please print)

Please complete all items in **PART B** and return this form within **seven days** to the claimant or forward it to the claimant's employer.

1. Claimant's Name: _____ 2. Age: _____ 3. ( ) Male ( ) Female

4. Diagnosis/Analysis:
   a) Claimant's symptoms: _____
   _____
   b) Objective Findings: _____
   _____

5. Claimant Hospitalized? ( ) No ( ) Yes From _____ to _____

6. Operation Indicated? ( ) No ( ) Yes Type _____ Date _____

7. Enter dates for the following:
   a) Date of your **first** treatment of this disability ……
   b) Date of most **recent** treatment of this disability ……
   c) Date Claimant unable to work due to disability ……
   d) Date Claimant can perform usual work ……..

Mo.	Day	Year

8. In your opinion, is this an occupational injury or illness? ( ) No ( ) Yes
   If "Yes", was a Workers' Compensation Claim filed? ( ) No ( ) Yes

9. Remarks (Attach additional sheet if necessary): _____
   _____

10. I am a _____ Licensed in (State) _____ License No.: _____
    Doctor's Signature _____ Date _____
    Doctor's Name (Print): _____ Telephone No.: _____
    Office Address: _____
    Number Street City/Town State Zip Code

PART C – EMPLOYER'S STATEMENT – To Be Completed By Employer (Please print)

1. Employee's Name: _____ Social Security No.: _____

2. Date of Hire: _____ ( ) Full-Time ( ) Part-Time 3. Birth Date: _____

4. Earnings 8 weeks prior to disability
   (Including week disability began)

			No. Days	Amount
Month	Day	Year	Worked	Paid

5. Check days normally worked:
   Mon. Tues. Wed. Thurs. Fri. Sat. Sun.
   ( ) ( ) ( ) ( ) ( ) ( ) ( )

6. Date Employee last worked: _____

7. Date returned to work: _____

8. Disability due to job: ( ) No ( ) Yes

Employer's Name: _____ Address _____
Completed by: _____ Title: _____ Date _____