North Atlantic States
CARPENTERS BENEFIT FUNDS
Health
Benefits Fund

Buffalo Office
1159 Maryvale Drive, Suite 20
Cheektowaga, NY 14225
Phone: 877-739-7136
Fax: 716-839-7136
carpentersfund.org

Long Island Office
270 Motor Parkway
Hauppauge, NY 11788
Phone: 877-372-3236
Fax: 631-952-9813
carpentersfund.org

Accident and Sickness Benefit

CLAIMANT FORM

Member Information

Member Name: _____ Date of Birth: _____

Member Address: _____

Member Email: _____ Phone Number: _____

Patient last four SSN or UBC#: _____

Disability Information

Is your disability related to an accident or injury? *(Select One)* ◯ Yes ◯ No

If yes, please describe **how, when**, and **where** the accident or injury occurred:

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If no, please briefly describe the cause of your disability:

Employer Information

Date you last worked: _____ (mm/dd/yyyy)

Employer Name: _____

Employer Phone Number: _____

Employer Address: _____

Member's Signature and Affirmation

I affirm that the information I have provided on this form is complete and true to the best of my knowledge and belief.

_____ _____

Member Signature **Date**

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Accident and Sickness Benefit

ATTENDING PHYSICIAN'S STATEMENT

Patient Information

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Patient Email: _____

Patient Gender: ◯ Male ◯ Female Patient last four SSN or UBC#: _____

Patient Information Related to Diagnosis, Treatment, and History

Please use date format: mm/dd/yyyy

Date you first consulted patient: _____

Primary ICD-10 Code: _____

Secondary ICD-10 Code: _____

Surgery Date: _____

Primary Procedure: _____

Date patient's symptoms first appeared, or accident/injury happened: _____

Is the patient's condition the result of a work-related accident or illness? ◯ Yes ◯ No

Date patient ceased work from condition: _____ Date patient became totally disabled: _____

Estimated Date of Return to Work: _____ Date of Next Appointment: _____

Other comments:

Treating Physician Information

Physician Name: _____

Specialty/Board Certification: _____

Physician Address: _____

Phone Number: _____ Fax Number: _____

Tax Identification Number: _____

_____ _____

Physician Signature: **Date:**