North Atlantic States Carpenters
Health Benefits Fund

**Massachusetts Office**
350 Fordham Road
Wilmington, MA 01887
www.carpentersfund.org
Phone: 800-344-1515
Fax: 978-752-1148

**Connecticut Office**
10 Broadway
Hamden, CT 06518
www.carpentersfund.org
Phone: 800-922-6026
Fax: 203-288-3235

# ACCIDENT & SICKNESS CLAIMANT FORM

## Section 1. Member Information

Member Name: _____ Date of Birth: _____

Social Security Number: _____ Phone Number: _____

Member Address: _____

## Section 2. Disability Information

Is your disability related to an accident or injury? *(Check One)* YES_____ NO_____

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

_____

_____

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

_____

## Section 3. Employer Information

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

Employer Name: _____ Phone Number: _____

Employer Address: _____

## Section 4. ***** IMPORTANT TAX WITHHOLDING INFORMATION *****

**The Short Term Disability Benefits are considered taxable income and must be reported on your income tax return. While the Fund automatically withholds FICA/Medicare taxes; the Fund does NOT automatically withhold Federal or Massachusetts State taxes from your Short Term Disability payments. If you would like the Fund to withhold Federal and Massachusetts State taxes from your Short Term Disability payments, you must complete and return the enclosed Form W4-S with this application. STATE Tax Withholdings: Please be advised that the Fund will withhold Massachusetts State taxes ONLY. If you reside outside of Massachusetts, State taxes will NOT be withheld from your benefit payments.**

**WAIVER of Tax Withholdings: If you do NOT want Federal and Massachusetts State taxes withheld from your Short Term Disability payments, please indicate by signing and dating within Section 4 below.**

**Member Waiver of Federal and Massachusetts State Tax Withholding Signature below:**

**Member Signature:** _____ **Date:** _____

***IMPORTANT NOTICE REGARDING UNEMPLOYMENT BENEFITS*:** Members collecting Unemployment benefits should NOT apply for Short Term Disability benefits. Both the Fund and Unemployment Department report benefit taxes to the Internal Revenue Service. The Unemployment Department will demand a full refund from you of Unemployment Benefits they paid to you during the time in which you were also collecting the Fund's Short Term Disability Benefits.

## Section 5. 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 & SICKNESS BENEFIT

## ATTENDING PHYSICIAN STATEMENT

**Section 1. Patient Information**

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Patient Gender: _____ Male _____ Female Patient SSN: _____

**Section 2. Patient Information related to Diagnosis, Treatment and History**

Date you first consulted patient: _____
mm/dd/yyyy

Primary ICD-10 Code: _____

Secondary ICD-10 Code: _____

Surgery Date: _____ Primary Procedure: _____
mm/dd/yyyy

Date patient symptoms first appeared, or accident/injury happened? _____
mm/dd/yyyy

Is condition due to accident or sickness arising out of patient's employment? _____ Yes _____ No

Date patient ceased work because of condition: _____
mm/dd/yyyy

Date member became totally disabled: _____
mm/dd/yyyy

Estimated return to work date: _____
mm/dd/yyyy

Date of Next Appointment: _____
mm/dd/yyyy

Other comments: _____

_____

**Section 3. Treating Physician Information**

Physician Name: _____ Specialty/Board Certification: _____

Physician Address: _____

Phone Number: _____ Fax Number: _____

Tax Identification Number: _____

**Physician Signature:** _____ **Date:** _____