SHEET METAL WORKERS HEALTH FUND OF LOCAL UNION #19 ACCIDENT & SICKNESS CLAIM FORM
1301 S. COLUMBUS BOULEVARD PHILADELPHIA, PA 19147
(215) 952-1990 FAX (215) 952-0142

(ALL FIELDS ON THIS FORM MUST BE COMPLETED BEFORE CLAIM IS PROCESSED)

MEMBER INFORMATION

PART I - TO BE COMPLETED BY THE MEMBER

Member/Patient's Last name: First: Middle:	Birth date: / /	Social Security no.:
Address (Street, City, State, Zip Code):		Home phone no.:

Nature of illness or injury:	Date accident or sickness commenced: / /	Last employer preceding disability:	Last day worked: / /

ACCIDENT INFORMATION:		**SECTION A:** (Name, address, number of other insurance company or representing attorney)
Where did accident happen?		
Is this a work related illness or accident?	☐ Yes ☐ No	
ls the disability a result of an auto accident?	☐ Yes ☐ No	
Is accident covered by another insurance carrier?	☐ Yes ☐ No	
lf you answered "Yes" to any of the above questions, please provide information on the insurance company or the attorney that is representing you in Section A.		

VOLUNTARY WITHHOLDING REQUEST:	I want federal income tax withheld from my benefit payments at a rate of 15% ☐ Yes ☐ No
Benefits are subject to FICA and Unemployment taxes. It is mandatory they are withheld from payments. Benefits are also subject to federal income tax and withheld at the request of the member.	
The above Information ls true to the best of my knowledge. I authorize Sheet Meta! Workers Health Fund of local Union #19 to release any Information required to process my claim.	

Member/Patient signature *Date*

MEDICAL AND PHYSICIAN INFORMATION

PART II -TO BE COMPLETED BY PHYSICIAN

Date of illness (first symptom) or injury: / /	First consulted for this condition: / /	Hospitalizations: Admitted: / / Discharged: / /
Date patient able to return to work: / /	First consulted for this condition: From: / / Through: / /	
Diagnosis or nature of illness or injury:		

Physician Name:	Address (Street. City, State. Zip Code):	Phone no: ( )	Soc. Sec./Tax I.D.:

Physician signature *Date*