SHEET METAL WORKERS
LOCAL NO. 110 HEALTH FUND

Administered by Southern Benefit Administrators, Incorporated

Mailing Address:
P.O. Box 1449
Goodlettsville, TN 37070-1449

Telephone: (615) 859-0131
Toll Free: (800) 831-4914
Fax: (615) 855-6159

Street Address:
2001 Caldwell Drive
Goodlettsville, TN 37072-3589

STATEMENT OF DISABILITY

IMPORTANT: Complete claim form fully and accurately.
Filing a false claim will result in legal action to the fullest extent possible and denial of future benefits.

EMPLOYEE'S STATEMENT

Name of Employee: _____ Full Social Security Number: _____

Home Address: _____

Marital Status ☐Married ☐Single Employee Date of Birth: _____

Employed by _____ Job Title: _____

Date of Accident (if applicable): _____ at (Hour): _____ AM / PM

Was the injured person at work when the accident happened? ☐Yes ☐No

Provide a brief description of the accident: _____

On what date where you first totally disabled by the sickness or injury? _____

Are you now wholly unable to physically engage in any work, occupation, or business? ☐Yes ☐No

On what date were you last treated by a physician for your disabling condition? _____

Have you returned to work? ☐Yes ☐No If yes, on what date? _____

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct, and complete. I hereby authorize any physician or hospital to furnish and disclose all known facts concerning this disability to Sheet Metal Workers Local No. 110 Health Fund. A copy or photocopy of this authorization shall be as valid as the original.

Employee's Signature: _____ Date: _____

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name: _____ Patient's Age: _____

Nature of sickness or injury. Describe complications and limitations, if any:

_____

_____

Date of first treatment: _____ Date of most recent treatment: _____

The patient has been continuously disabled (unable to work in any occupation) from: (Date) _____through (Date) _____

Remarks:

_____

Physician's Signature: _____ Date: _____

Physician's Printed Name: _____

Physician's Address and Telephone Number: _____