

OPERATING ENGINEERS TRUST FUNDS

I.U.O.E. LOCAL 12 HEALTH & WELFARE / PENSION / VACATION / TRAINING

100 CORSON STREET, SUITE 100 • PASADENA, CALIFORNIA 91103 • (866) 400-5200
 P.O. BOX 7063, PASADENA, CALIFORNIA 91109
 TTY: (626) 356-3582 WEBSITE: www.oefi.org



Nevada Weekly Disability Benefit Application

Participant's Information			
Social Security Number/OE ID	Last Name	First Name	Middle
Address Information			
Mailing Address	City	State	ZIP Code
Employer's Name	Home Phone Number ()	Mobile Phone Number ()	
Part A – To be completed by the employee			
Are you still disabled?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If not, when did you recover?	____/____/____
Date and time you stopped working	____/____/____ at _____	Have you worked for a wage or salary since your disability began?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this disability in any way related to your employment or occupation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	What date do you expect to return to work?	____/____/____
Are you receiving or have you filed a claim for benefits under the federal Social Security Disability Act? If yes, provide date of approval and benefit amount.			
<input type="checkbox"/> Yes <input type="checkbox"/> No	Date ____/____/____	Amount per month \$	_____
I hereby certify that the forgoing statements, including any accompanying statements, are true, correct and complete to the best of my knowledge and hereby further authorize my attending physician, practitioner or hospital in which confinement took place to furnish and disclose all facts concerning my physical condition that are within their knowledge.			
Signature (required)			
X _____			Date ____/____/____
Part B – Attending Physician's Statement			
Patient's Name		Patient's Date of Birth ____/____/____	
Nature of Sickness or Injury (describe complications if any)		Is this condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No	
The patient has been continuously disabled (unable to work) from ____/____/____ to ____/____/____	Date of most recent treatment: ____/____/____	What date is patient expected to return to work? ____/____/____	
ICD.9 Code(s)			
Physician Name	Physician Tax ID #	Phone Number ()	
Mailing Address	City	State	ZIP Code
I hereby approve release of information pertaining to hospital confinement of this patient to Operating Engineers Health & Welfare Fund on authorization of patient.			
Attending Physician's Signature			
X _____			Date ____/____/____

Return to: Operating Engineers Health and Welfare Fund, PO Box 7067, Pasadena, CA 91109