DISTRICT COUNCIL 37 HEALTH & SECURITY PLAN
125 BARCLAY STREET, NEW YORK, NY 10007

SHORT-TERM DISABILITY BENEFIT CLAIM

Phone: (212) 815-1234

THIS CLAIM MUST BE RECEIVED WITHIN 30 DAYS FROM THE DAY YOU BECOME DISABLED REGARDLESS OF SICK, VACATION OR ANNUAL TIME. PLEASE EMAIL IT TO DisabilityUnit@DC37.NET or FAX to 212-298-9886

EMPLOYEE INFORMATION

Name _____ Soc. Sec. # /PID # _____

Address for Payment _____
No. & Street Apt # City Zip

Gender___ **Email** _____@_____ **Cell #** _____

JOB INFORMATION

Agency _____ Job Title _____

Work Address _____ **Timekeeper Phone #** _____

Timekeeper Name & Email _____

Did you apply for 3.5, dedicated or donated leave grant? _____ If school worker, indicate District # & Phone # _____

If **pregnant**, what dates did you apply for Paid Family Leave? _____ Hours worked per day _____

Please submit a copy of your LEAVE REQUEST or APPROVAL with your application.

ILLNESS INFORMATION

How many sick days did you have on the date you became disabled? _____

What is the last date you worked? _____ Name of doctor _____

Describe your illness _____

Have you returned to work yet? Yes□ No□ If yes, what date? _____

Have you ever received disability payments for the same illness? **YES**□ NO□ If yes, what year? _____

IF CONFINED IN HOSPITAL

Name of Hospital _____

Address of Hospital _____

Date Admitted _____ Date Discharged _____

IF DISABILITY IS DUE TO ACCIDENT

A. Date of accident _____ B. How & where & when did it happen? _____

_____

_____

C. Did it happen at work? **YES** ☐ NO□ D. Did you file for Workers' Compensation? **YES**□ NO□

E. Is there a lawsuit? **YES** ☐ NO□

F. If yes, give attorney's name _____

Address _____ Phone # _____

SIGN HERE

The above statements are true and complete to the best of my knowledge and belief and I hereby authorize any hospital or physician who has treated me to furnish any and all medical information to District Council 37 Health & Security Plan.

Signature _____ Date _____
SIGNATURE

BY SIGNING THIS CLAIM APPLICATION, YOU AGREE TO ENROLL INTO THE DC 37 HEALTH & SECURITY PLAN TO RECEIVE SHORT-TERM DISABILITY, PRESCRIPTION, DENTAL, AUDIOLOGY, OPTICAL, SOCIAL WORK & MORE.

DISTRICT COUNCIL 37 HEALTH & SECURITY PLAN

DisabilityUnit@dc37.net
Fax: 212-298-9886

125 BARCLAY STREET, NEW YORK, NY 10007

ATTENDING PHYSICIAN'S STATEMENT

Patient: _____ **Claim No.** _____ **Age:**_____ **Gender:**___

DIAGNOSTIC CATEGORY

A. Medical Conditions/Diagnosis

(IMPORTANT: **THIS CLAIM CANNOT BE PROCESSED WITHOUT THE APPROPRIATE ICD 10 CODES.*)***

	ICD CODE (required)	DESCRIPTION
Primary Diagnosis	_____ _____	_____
Secondary Diagnosis	_____ _____	_____
	_____ _____	_____

Is patient's disability related to Substance Abuse YES ☐ NO ☐ and/or Alcoholism YES ☐ NO ☐
Is patient's disability related to an accident? **YES** ☐ NO ☐
Is patient's disability a result of an injury arising out of and in the course of employment or an occupational disease? **YES** ☐ NO ☐

TREATMENT INFORMATION

B. Specific Dates of Treatment for this illness: _____ ; _____ ; _____ ; _____ ; _____

If hospitalized for this disability: Date Admitted _____ Date Discharged_____
Name of Hospital:_____ Address:_____
If surgery was performed, give the date(s):_____
Type of Surgery: *(with **CPT** code)* _____
If pregnancy, list date, or expected Date of Delivery:_____
Type of delivery: Normal ☐ C-Section ☐

C. Therapy

Is patient receiving Chemotherapy, Radiation or on Dialysis? YES ☐ NO ☐
If yes, give dates: _____ ;_____ ; _____ ;_____ ; _____; _____ ; _____; _____
Is patient receiving Physical Therapy? YES ☐ NO ☐
If yes, give dates: _____ ;_____ ; _____ ;_____ ; _____; _____ ; _____; _____
Is patient in a program for Substance/Alcohol Abuse? YES ☐ NO ☐
Name of Program _____ Phone #_____
Dates in attendance: _____ ; _____ ;_____; _____; _____ ; _____ ; _____

D. Anticipated Duration for this Disability (required)

(Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)
Patient's disability is expected to extend from_____ through_____

SIGN HERE

Physician's Signature	Name (Print)	**Degree Specification**
Licensed in the State of	License Number	
Address	Phone	Date

DC 37 Health & Security, Attn: Disability Unit, 125 Barclay Street, New York, NY 10007

Employee's Name: _____

Employer: _____

Job Title: _____

Last 4 digits of SS #: xxx-xx-_____

Dear Timekeeper or Payroll Specialist,

The above employee has submitted a short-term disability claim to DC 37. Please provide the following information so we can process their claim application. Thank you.

1) What is the last day that the employee worked? _____
    a. What was the employee's sick time balance as of the last day worked? _____
    b. What type of leave has the employee been on since last date worked? _____
        i. Please provide dates of leave. _____
2) If the employee has returned to work, when? _____
3) Does the employee work Mon through Fri? _____
    a. If no, what days do they work & how many hours per day? _____
    b. How many hours per day do they typically work? _____
4) Has the member retired, resigned or been terminated? _____
    a. If yes, please provide status and effective date. _____
5) Has member applied or been approve for a 3.5 grant or extended sick leave with pay? _____
    a. If yes, provide dates. _____
6) Did employee apply for workers' compensation?_____ If yes, provide last pay period._____
7) Did employee apply for paid family leave? If yes, provides start & end dates._____
8) For ONLY public school workers, what dates is employee scheduled to work during summer months? _____

I affirm that to the best of my knowledge and belief, the information I have provided is true and accurate.

Timekeeper's name: _____

Timekeeper's signature: _____

Timekeeper's title: _____

Timekeeper's phone #: _____

Date completed: _____

Please return to: **DisabilityUnit@dc37.net** or fax to 212-298-9886 – Questions? Call 212-815-1234

DC 37 Health & Security Plan

125 Barclay St., New York, NY 10007 - 212-815-1234

Dear Member,

Health & Security wants to ensure you have access to your benefits while you are recovering from an illness or injury. To help us process your short-term disability claim application faster, please read the tips below:

- Your claim should be submitted within **30 days** from your last day worked to avoid interruption of income. If you are applying after the deadline, please include a written explanation of the delay to prevent denial.
- If you are planning to **leave the NYC Metropolitan area** while applying or receiving disability benefits, you must request approval from DC 37 Health & Security otherwise your claim will be declared ineligible.
- If you were in an **accident** or victimized in a crime, please describe how, when & where it happened. Please include an accident or police report with your claim.
- If you are **pregnant**, please apply for disability after your expected delivery date. Consult with your disability claim examiner before requesting Paid Family Leave since you cannot receive both during the same period. If your doctor considers your pregnancy is **high-risk** and recommends you stop working more than 4 weeks before your delivery date, then apply immediately and have your doctor include your prenatal records and a clinical note. Don't forget to add your new child to your H&S Benefits by emailing the birth certificate to eeu@dc37.net.
- Please take the time to update your DC 37 Health & Security **beneficiary** by emailing eeu@dc37.net or calling 212-815-1234. Currently, the death benefit is $10,000 for full-time workers, $6,000 for part-time workers, $2000 for most retirees & $1000 for retirees from cultural institutions.

Page 2 of the claim form is to be **completed only** by a licensed medical doctor. You should not complete or alter any of the information in this section. Check to be sure that your doctor has filled out all the information requested in each section (Parts A-D) and signs the form.

Page 3 of the claim form is to be **completed only** by your timekeeper at your workplace.

You, your physician, or timekeeper may email your completed Short-Term Disability Benefit Claim form and supporting documents to **DisabilityUnit@dc37.net** or fax it to 212-298-9886.

In solidarity,

K. Gomez

Kevin Gomez

Disability & Death Benefits Unit Manager