



DISTRICT COUNCIL 37 HEALTH & SECURITY PLAN

HS:DIS 013

55 WATER STREET, NEW YORK, NY 10041

This is a Writable Form

SHORT-TERM DISABILITY BENEFIT CLAIM

Phone: (212) 815-1390

TO BE FULLY COMPLETED BY EMPLOYEE AND FILED WITHIN 15 DAYS FROM THE DAY YOU BECOME DISABLED REGARDLESS OF SICK, VACATION OR ANNUAL TIME.

EMPLOYEE INFORMATION	Name _____ Soc. Sec. No./PID _____
	Home Address _____ <div style="display: flex; justify-content: space-between;"> No. & Street City State Zip </div>
	Date of Birth _____ Male <input type="checkbox"/> Female <input type="checkbox"/> Home Phone _____

JOB INFORMATION	Name of your work place _____ Date of Employment _____
	Work Address _____ Timekeeper Personnel Phone No. _____
	Department _____ Payroll _____
	Job Title _____ If school worker, District Office No. _____
	Annual Salary _____ Hours worked per day _____
	How many sick days did you have on the date you became disabled? _____

ILLNESS INFORMATION	When did you become totally disabled so that you could not work? Date: _____
	What date did you first see a doctor? _____ Name of doctor _____
	Describe your illness _____
	Have you returned to work yet? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what date? _____
	Have you ever received disability payments for the same illness? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what year? _____
	IF CONFINED IN HOSPITAL
	Name of Hospital _____
	Address of Hospital _____
	Date Admitted _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Date Discharged _____
	IF DISABILITY IS DUE TO ACCIDENT
A. Date of accident _____ <input type="checkbox"/> AM <input type="checkbox"/> PM B. How did it happen? _____	
C. Did it happen at work? Yes <input type="checkbox"/> No <input type="checkbox"/> D. Did you file for Workers' Compensation? Yes <input type="checkbox"/> No <input type="checkbox"/>	
E. Is there a lawsuit? Yes <input type="checkbox"/> No <input type="checkbox"/>	
F. If yes, give attorney's name _____ Address _____ Phone No. _____	

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 _____ <div style="text-align: center;">SIGNATURE</div>

IF YOU ARE PLANNING TO GO OUT OF THE NEW YORK AREA AFTER YOU HAVE APPLIED FOR DISABILITY BENEFITS, YOU MUST CONTACT THE HEALTH & SECURITY PLAN OFFICE OR YOUR CLAIM WILL BE DECLARED INELIGIBLE.

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55 WATER STREET, NEW YORK, NY 10041

(212) 815-1390

ATTENDING PHYSICIAN'S STATEMENT

Patient: _____ Claim No. _____ Age: _____ Sex: _____

DIAGNOSTIC CATEGORY

A. Medical Conditions/Diagnosis

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

	ICD CODE	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 Abuse? YES NO

Name of Program _____ Telephone Number _____

Dates in attendance: _____ ; _____ ; _____ ; _____ ; _____ ; _____ ; _____

D. Anticipated Duration For This Disability

(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

55 Water Street
New York, N.Y. 10041
Telephone: (212) 815-1390

Health & DC37 Security Plan

Dear Member:

In consideration of the COVID-19 situation the DC37 Health & Security Plan is making some temporary changes to enable our members easier access to disability benefits. Follow the instructions below so that we may process your claim as quickly as we can.

Disability claim forms received by our office are frequently delayed or returned to the member because they are incomplete. Your Claim May Be Delayed Or Returned Unless You Do The Following:

- Sign your claim. (Electronic signature is acceptable)
- Give the phone number of your timekeeper/payroll/personnel department.
- Describe your illness.
- If you were involved in an accident, indicate how, when and where you were injured.
- Make certain your Social Security number/ and or PID# is correct.
- Enclose a copy of your Marriage/Divorce/Separation papers if you have changed your name.

The “Physician’s Statement” section of the claim form is to be entirely completed and only by a licensed medical doctor.

You should not complete or alter any of the information in this section. Check particularly to be sure that your doctor includes dates of all treatments and expected duration of your disability.

You or your physician may fax your completed disability form and supporting documents to (212) 298-9886. If you do not have access to a fax machine you may email your documents to us at disabilitydeath@dc37.net. Processing can be expedited much faster if you use fax or email.

If you have any questions please 212-815-1390.

Very truly yours,

Dennise Frank

Dennise Frank
Acting Unit Manager
Disability & Death Unit