

SHOPMEN'S LOCAL 527 BENEFIT FUND
2945 BANKSVILLE ROAD
PITTSBURGH, PA 15216
(412) 341-6183
Toll Free # 1 (800) 858-7870

ACCIDENT AND SICKNESS CLAIM GROUP INSURANCE

FORM TO BE COMPLETED BY THE PHYSICIAN AND RETURNED TO THE FUND OFFICE IMMEDIATELY

PART A - ATTENDING PHYSICIAN'S STATEMENT

1. Diagnosis and Concurrent Conditions

2. Is Condition Arising From:

Patient's Employment? Yes () No () Accident Non-Work Related? Yes () No ()

Pregnancy? Yes () No () If yes, approximate date pregnancy commenced. Date:

3. Date of Services

(If previous form submitted, you need show only dates since last report)

Office _____

Home _____

Hospital _____

4. Date Symptoms First Appeared

5. If Accident, Give Description

6. Has Patient Ever Had Same or Similar Condition?
 Yes () No () If "Yes" - When and Describe:

7. Date Patient First Consulted You for This Condition:
 Is Patient Still Under Your Care for This Condition: Y() N()

8. Patient Was Continuously Disabled (Unable to Work).
 (Please Estimate)
 From _____ Through _____

9. Patient Was Partially Disabled.
 From _____ Through _____

10. If Still Disabled, Date Patient Should Be Able to Return
 to Work:

11. Patient was House Confined:
 From _____ Through _____

12. Does Patient Have Other Health Coverage?
 Yes () No () If "Yes" - Please Identify

| | | | | |
|------|---------------------------------|-----------|--------|-----------|
| DATE | PHYSICIAN'S NAME (Please Print) | SIGNATURE | DEGREE | TELEPHONE |
|------|---------------------------------|-----------|--------|-----------|

| | | | |
|----------------|--------------|-------------------|----------|
| STREET ADDRESS | CITY OR TOWN | STATE OR PROVINCE | ZIP CODE |
|----------------|--------------|-------------------|----------|

PART B - TO BE COMPLETED BY PATIENT (INSURED)

PATIENT'S NAME AND ADDRESS

DATE OF BIRTH

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize _____ SIGNED (Patient, or Parent if Minor)
 the undersigned physician to release any information acquired in the
 course of my examination or treatment.

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You must notify the Fund Office immediately on your return to work by calling 1(800) 858-7870. This authorization must be signed in advance of any payment of benefits, but will only be used to recover any over payment received by the claimant and kept. This will authorize you to deduct the sum of \$_____ per week from my earnings commencing _____ for the purpose of reimbursing Shopmen's Local 527 Benefit Fund in the amount of \$_____ which represents an over payment which I received from the Accident and Sickness Program. This payroll authorization is to remain in effect until such time as I have reimbursed the Fund in full. I would appreciate your transmitting the full amount of \$_____ to Shopmen's Local 527 Benefit Fund.

Witness _____ Signature of Member _____

Social Security No. _____ Telephone No. _____