OPERATING ENGINEERS TRUST FUNDS

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

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?	☐ Yes ☐ 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?	☐ Yes ☐ No
Is this disability in any way related to your employment or occupation?	☐ Yes ☐ 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.

☐ Yes ☐ 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? ☐ Yes ☐ No

The patient has been continuously disabled (unable to work) from	Date of most recent treatment:	What date is patient expected to return to work?
____/____/_____ to ____/____/_____	____/____/_____	____/____/_____

ICD-10 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