



Carpenters Southwest Administrative Corporation

ADMINISTRATIVE OFFICE: 533 S Fremont Ave. • Los Angeles, CA 90071-1706 • Tel: (213) 386-8590 • Toll Free (800) 293-1370

www.carpenterssw.org

DISABILITY INITIAL CLAIM FORM

Part I - Member Statement (Please Print) Please see other side of this form for benefit qualifications

- I hereby apply for benefits due me on account of an illness or injury which has caused me to be continuously unable to work since _____, 20_____
- Name _____ SS# or UBC number _____ Date of Birth _____ Local Union# _____
- Address _____ City _____ State _____ Zip _____ Phone: _____
- Was the disability as a result of your occupation? _____ Yes _____ No
- When did illness/injury begin? _____
- Cause of disability (describe illness or injury) _____
Where did it occur? _____
- Name of doctor first consulted? _____ Date of first Visit _____
- Date of return (or expected return) to full-time work _____

I hereby certify that the foregoing answers are true and correct to the best of my knowledge and hereby authorize all doctors or other persons who treated me, and all hospitals or other institutions, to furnish full information (including copies of records) regarding this claim to the Southwest Carpenter's Health & Welfare and Pension Trust Office. A copy or photocopy of this authorization shall be as valid as the original.

- Signature of Member _____ Date _____

Part II - Physician Statement (Please Print)

- Name of patient _____
- Did the illness or injury arise out of the patient's employment? _____ Yes _____ No
- With regard to this injury or illness, is the patient able to return to FULL DUTY work? _____ Yes _____ No
- If NO, for how long? From (initial date of disability) _____ To (expected return to work date) _____
- When did the patient first consult you for this condition? _____
- When did the accident or symptoms first occur? _____
- Dates of treatment or service _____ Diagnosis/CD9 code _____
- Is disability being reported to the patient's Workers' Compensation carrier or another health coverage? _____ Yes _____ No
- If yes, please identify _____
- If hospitalized, please give dates _____

Physician's Name (Please Print) _____ Degree _____

Phone # _____ Fax # _____

Address _____ City _____ State _____ Zip _____

Physician's Signature: _____ Date: _____

SOUTHWEST CARPENTERS ADMINISTRATIVE OFFICE USE ONLY			
Last Eligible Quarter _____		Reserve Hours _____	
1st Quarter		2nd Quarter	
Mo/Yr	Hours	Mo/Yr	Hours
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Total	Date	Total	Date
Applied	Processor	Applied	Processor

Revised 1/11

Arizona
Satellite Office
4547 W. McDowell Rd. Ste. 6
Phoenix, AZ 85035-4124
(602) 352-6805

Nevada
Satellite Office
980 Kelly Johnson Dr., Ste. 180
Las Vegas, NV 89119-3722
(702) 851-4510 • (800) 501-0210

New Mexico
Satellite Office
3900 A Pan American Freeway, NE Ste. 120
Albuquerque, NM 87107-4747
(505) 266-8869