SOUTHERN CALIFORNIA PIPE TRADES HEALTH & WELFARE FUND
501 Shatto Place, Suite 500, Los Angeles, CA 90020 | (800) 595-7473 (213) 385-6161 | Fax (213) 487-3640 | www.scptac.org | disability@scptac.org

APPLICATION FOR WEEKLY ACCIDENT & SICKNESS (TOTAL DISABILITY) BENEFITS

PART 1 – PARTICIPANT'S STATEMENT

Participant Name _____ Date of Birth _____

Social Security Number (only last four digits required) _____ **OR** IPE T50 _____ Blue Shield Participant ID No.

Address _____

Phone number _____ Email Address _____

Last day of work _____ First full day of disability _____ Last full day of disability (if known) _____

I hereby claim Weekly Accident and Sickness (Total Disability) benefits from the Southern California Pipe Trades Health & Welfare Fund ("Fund"). I certify that, for the period covered by this claim, I was not working and was totally disabled (defined by the Fund as "wholly prevented by bodily Injury or Illness from engaging in any occupation or employment"). I certify that the information provided on this form is, to the best of my knowledge and belief, true and complete. I hereby authorize my physician to disclose to the Fund all facts concerning my physical condition, including any relevant Protected Health Information.

X _____ Participant signature _____ Date

PART 2 – PHYSICIAN'S STATEMENT

Physician name (please print) _____ ☐ M.D. ☐ D.P.M. ☐ D.O. ☐ D.C. Phone number _____

Address _____

Disability is due to: ☐ Accident ☐ Illness _____ Nature of Participant's Illness or Injury

Diagnosis Code _____ First full day of disability _____ Last full day of disability (if known) _____

Please attach any additional remarks you believe may be helpful to the Fund in rendering a decision.

If the Participant is still disabled, the date you expect him or her to be able to return to work: _____

I certify that the Participant listed above has been Totally Disabled (defined by the Fund as "wholly prevented by bodily Injury or Illness from engaging in any occupation or employment"), during the period(s) indicated.

X _____ Physician Signature _____ Date

Revised February 2024