MICHIGAN ELECTRICAL EMPLOYEES' HEALTH PLAN

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www.michiganelectrical.org

APPLICATION FOR ACCIDENT/SICKNESS WEEKLY DISABILITY BENEFIT

(**Note: Participant must complete this side**
Reverse side must be completed by your physician)

Name:			Date of Birth:
Address:	City:	State:	Zip:
MID or SS #:	Telephone #		Local Union #:
Name of Present or Last Employer	Current or Last Hourly Wage Amount : $		
Is this claim based on an accident/injury?		Yes ☐	No ☐
Nature of sickness or accident/injury:			
Date sickness or accident/injury began:			Date first treated:
Did sickness or accident/injury occur in the course of employment?		Yes ☐	No ☐
Where did sickness or accident/injury occur?			
How did sickness or accident/injury happen?			
Have you, or do you intend to file this claim under Workers' Compensation?		Yes ☐	No ☐
On what date did you last work?			
Have you resumed work?		Yes ☐	No ☐
If YES, what date:			
Signature:			Date:

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ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT
(YOU MUST BE EXAMINED BY A PHYSICIAN AND CERTIFIED AT LEAST EVERY 6-8 WEEKS)

Patient's Name:		Date of Birth:
Diagnosis and Concurrent Conditions:		
Is this claim based on an accident/injury?	Yes ☐	No ☐
Date sickness or accident/injury began:	Date first treated:	
Is condition due to injury or sickness arising out of patient's employment?	Yes ☐	No ☐
If YES, explain:		
This patient has been continuously disabled (first day unable to work) from _____ through (last day unable to work) _____.		
Exact date patient will be able to return to work at trade:		
If exact date is unknown, please estimate:		
Is patient still under your care for this condition?	Yes ☐	No ☐
If YES, give date of last treatment:		
If YES, give date of next scheduled appointment:		
If NO, give date treatment terminated:		
Physician's Signature:		Date:
Physician's Name (please print)		Degree: (check one) ☐ M.D. ☐ D.O.
Address:		
City:	State:	Zip:
Telephone Number: Fax Number:		