MARITIME ASSOCIATION - I.L.A. ACCIDENT & SICKNESS BENEFITS APPLICATION

ELIGIBILITY: Class 2 or Class 3 Employee with a minimum of 1,400 Credit Hours during the immediately prior Eligibility Year.

PART I — TO BE COMPLETED BY BUSINESS AGENT PRIOR TO FIRST PAYMENT

NAME OF EMPLOYEE	SOCIAL SECURITY NUMBER
LAST DATE WORKED BEFORE LATEST PERIOD OF DISABILITY	FIRST DATE WORKED AFTER RECOVERY (if employee has returned to work)
TODAY'S DATE	BUSINESS AGENT'S SIGNATURE (only to be signed by an authorized Local Representative)
LOCAL NUMBER	BUSINESS AGENT'S TELEPHONE NUMBER

PART II — TO BE COMPLETED BY EMPLOYEE FOR EACH PAYMENT

NAME	SOCIAL SECURITY NUMBER	LOCAL NUMBER

STREET ADDRESS: street and number city state zip code

HOME TELEPHONE NUMBER	DATE OF BIRTH	AGE	MALE	FEMALE

DATE ACCIDENT OCCURRED OR SICKNESS BEGAN:

IF ACCIDENT:

WHERE DID THE ACCIDENT HAPPEN: _____ WAS THIS AN AUTOMOBILE ACCIDENT: _____

HOW DID ACCIDENT HAPPEN: _____

DID ACCIDENT HAPPEN WHILE YOU WERE AT WORK: _____ ARE YOU PRESENTLY RECEIVING ANY PAYMENT FROM ANY EMPLOYER: _____

ARE YOU PRESENTLY RECEIVING OR DO YOU HAVE A CLAIM PENDING FOR WORKERS' COMPENSATION : _____

AUTHORIZATION: I hereby authorize the undersigned physician to release to Maritime Association - I.L.A. Welfare Fund and/or its legal representative any information he or she possesses which is pertinent to my Accident & Sickness Benefit claim. A copy of this authorization is considered as valid as the original and is effective for the duration of this claim.

EMPLOYEE SIGNATURE: _____ TODAY'S DATE: _____

PART III — TO BE FULLY COMPLETED BY PHYSICIAN FOR EACH PAYMENT

PLEASE GIVE FULLY COMPLETED FORM TO PATIENT AT TIME OF OFFICE VISITS OR MAIL TO: Maritime Association-ILA Welfare Fund
11550 Fuqua, Suite 425
Houston, Texas 77034
(281) 484-4343 Switchboard

PHYSICIAN/PATIENT CONTACT REQUIRED NOT LESS THAN MONTHLY FOR PAYMENT OF ACCIDENT & SICKNESS BENEFITS.

DATE OF ILLNESS/INJURY	IF INJURY, WAS THIS JOB RELATED	DATE FIRST CONSULTED YOU FOR THIS CONDITION

DIAGNOSIS AND CONCURRENT CONDITIONS:

CURRENT TREATMENTS AND MEDICATIONS

FREQUENCY OF TREATMENTS	MOST RECENT TREATMENT DATE

IS SURGERY PLANNED/BEEN PERFORMED YES NO INPATIENT OUTPATIENT	TYPE OF SURGERY	DATE:

IF HOSPITALIZED, GIVE DATES: FROM: _____ TO: _____

DATES OF PATIENT'S DISABILITY: FROM: _____ TO: _____

DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK: DATE: _____

PHYSICIAN'S NAME, ADDRESS AND TELEPHONE NUMBER (ALL INFORMATION REQUIRED)

PHYSICIAN SIGNATURE TODAY'S DATE: _____

(rev.06-03)