MARITIME ASSOCIATION - I.L.A. WELFARE FUND OFFICE
11550 FUQUA, SUITE 425
HOUSTON, TEXAS 77034
pvwoffice@ma-ila.org
Telephone: (281) 484-4343 Fax: (281) 652-9061

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

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

PART I TO BE COMPLETED BY THE BUSINESS AGENT

NAME:	**MEMBER SSN:**	**LOCAL:**
LAST DATE WORKED BEFORE LATEST PERIOD OF DISABILITY:	**HAS EMPLOYEE RETURNED TO WORK? _____ YES _____ NO**	
	IF YES, PROVIDE THE DATE EMPLOYEE RETURNED TO WORK:	

ACKNOWLEDGEMENT: I CERTIFY THE ANSWERS I HAVE PROVIDED ABOVE ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE:	**SIGNATURE OF BUSINESS AGENT**	**TELEPHONE NO:**

PART II TO BE COMPLETED BY EMPLOYEE FOR EACH PAYMENT

NAME:	**SSN:**		**LOCAL:**
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
TELEPHONE:	**EMAIL:**		**DATE OF BIRTH:**

DATE YOUR DISABILITY BEGAN:

IS YOUR DISABILITY WORK RELATED? _____ YES, WORK RELATED _____ NO, NOT WORK RELATED

IS YOUR DISABILITY THE RESULT OF AN ACCIDENT? _____ YES _____ NO IF YES, COMPLETE THE FOLLOWING:

DATE OF ACCIDENT: IS THE ACCIDENT WORK RELATED? ___ YES ___ NO AUTO ACCIDENT? ____ YES ____ NO

HOW DID THE ACCIDENT HAPPEN?

ARE YOU CURRENTLY RECEIVING ANY PAYMENT FROM ANY EMPLOYER? ____ YES ____ NO

ARE YOU CURRENTLY RECEIVING OR HAVE A CLAIM PENDING WORKER'S COMPENSATION BENEFITS? ____ YES ____ NO

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

EMPLOYEE'S SIGNATURE: DATE:

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

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

DIAGNOSIS:

DATE OF FIRST VISIT:	**DATE OF FIRST VISIT FOR THIS PERIOD OF DISABILITY (if different):**
FREQUENCY OF VISITS: ___ Weekly ___ Monthly ___ Other	**MOST RECENT TREATMENT DATE:**

CURRENT TREATMENT AND MEDICATIONS:

IN HOSPITAL STAY: ____ Yes _____ No	**OUTPATIENT: ____ Yes ____ No**	**ADMIT DATE: DISCHARGE DATE:**
SURGERY: ____ Yes ____ No	**SURGERY DATE:**	**TYPE OF SURGERY:**
DATE THIS DISABILITY BEGAN:	**IS PATIENT STILL TOTALLY DISABLED AND UNABLE TO WORK? ____ YES ____ NO**	

HAS THE PATIENT BEEN RELEASED TO RETURN TO WORK? _____ No _____ Yes If yes, provide release date:

IF THE PATIENT HAS NOT BEEN RELEASED TO RETURN TO WORK, WHAT DATE SHOULD THE PATIENT BE ABLE TO RETURN TO WORK?

_____ UNABLE TO DETERMINE, FOLLOW UP IN _____ WEEKS _____ PERMANENTLY

PHYSICIAN'S NAME (please print): TELEPHONE: FAX:

ADDRESS: CITY: STATE: ZIP:

Acknowledgement: I certify the answers I have made to the above questions are complete and true to the best of my knowledge and belief.

Physician's Signature: Date: