SOUTHERN CALIFORNIA PIPE TRADES HEALTH & WELFARE FUND
501 Shatto Place, 5th Floor, Los Angeles, CA 90020 | (800) 595-7473 (213) 385-6161 | Fax (213) 487-3640 | www.scptac.org

APPLICATION FOR
Weekly Accident & Sickness (Total Disability) Benefits
All Sections Must Be Completed

PART 1 – PARTICIPANT'S STATEMENT

Name _____ Blue Shield Participant ID# or SSN (only last four required) _____

Address _____

Phone number and/or email address _____ Date of birth _____

First full day of disability _____ Last full day of disability (if known) _____ Disability is due to: ☐ Accident ☐ Illness

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

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

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

I certify that the Participant listed above has been Totally Disabled, which is 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