MUTUAL RELIEF FUND

Bricklayers and Allied Craftworkers
Local Union 1 Minnesota/North Dakota
312 Central Avenue, Suite 328
Minneapolis, MN 55414

Claim for Accident and Illness Benefits

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This form must be submitted by the individual claimant to the Union Office properly and ***fully*** completed by the member and his physician. ***No payment shall be allowed unless the accident or illness is reported within 90 days of occurrence and the member is current in their dues.*** A new claim form must be submitted each time during period of disability in order for claimant to continue to receive benefits. ***No Mutual Relief benefits allocated for Chiropractic care.***

TO BE COMPLETED BY MEMBER

Name_____ Date_____
Address_____ IU Number_____
Street
City_____ State_____ Zip Code_____ Soc. Sec. #_____
Date Accident Occurred_____
Date First Treated by a Physician_____ Did Accident Occur at Work? Yes_____ No _____
Name of Employer (if at work) _____
Accident Occurred at (address) _____
Describe Accident or Illness

Extent of Injuries_____

Date you expect to return to work_____

_____
Signature of Claimant

ATTENDING PHYSICIAN'S STATEMENT

Date_____
Patient's Name_____
Nature of injury or sickness (Describe) _____
_____
_____
Did these injuries arise out of patient's employment? Yes_____ No_____
If yes, please explain_____

Does treatment relate to a new injury or aggravation of former injury? _____
_____
The patient has been continuously disabled (unable to work) from _____20_____ through_____20_____
If still disabled, date patient should be able to return to work_____20_____
If patient has been cleared to return to work, date of discharge by you _____20_____
Remarks_____
_____

_____ _____
Physician's Name (Please Print) ***Physician's Signature***

Address_____

_____

Phone (_____) _____