



Writers' Guild-Industry Health Fund

Terence L. Young, Chief Executive Officer

DISABILITY APPLICATION FORM

TO AVOID DELAY BE SURE ALL QUESTIONS ARE ANSWERED COMPLETELY

Date: _____

This section is to be completed by the Employee/Participant:

Last First MI Date of Birth Social Security

Address City State Zip Code Telephone

Describe in details what caused your injury/disability. If you need additional space attach your statement to the back of this form.

Were you confined to the hospital? Yes No

Give first date treated for this injury/disability ___/___/___

Last date of work ___/___/___ Date you expect to return to work ___/___/___

Are you receiving benefits as a result of this injury/disability? Yes No

If yes, please indicate type below:

SOURCE	DATE BENEFIT BEGAN
State Disability <input type="checkbox"/>	
Social Security <input type="checkbox"/>	
Federal /State <input type="checkbox"/>	
Worker's Compensation <input type="checkbox"/>	
Pension <input type="checkbox"/>	
Other <input type="checkbox"/>	

Attending Physician's Information:

Physician's Name Address City Zip Code Telephone

This section is to be completed by the Attending Physician:

Patient's Name _____ Patient's Date of Birth _____ / ____ / ____

Employer's Name _____ Policy Number _____

1. HISTORY

- a) When did symptom first appear or accident happen? ____ / ____ / ____
- b) Date patient stopped work because of disability ____ / ____ / ____
- c) Has patient ever had same or similar condition? Yes No

If "Yes" give date(s) and details on the lines provided below:

- d) Is condition due to injury/sickness from employment? Yes No Unknown
- e) Give names and addresses of other treating physicians _____

2. DATES OF TREATMENT FOR DISABLING CONDITION

- a) Date of first visit ____ / ____ / ____
- b) Date of most recent visit ____ / ____ / ____
- c) Frequency Wkly Mthly Other (specify) _____

PROGRESS

- a) Has patient Recovered? Improved? Unchanged? Retrogressed?
 - b) Is patient Ambulatory? House Bed Hospital confined?
 - c) Due to this illness/injury has patient been hospital confined? Yes No
- If yes, give name, address and date(s) confined to hospital:

Name of Hospital _____ Address _____ City _____ Zip Code _____ Date(s) Confined _____ / ____ / ____

3. PHYSICAL IMPAIRMENT (* as defined in Federal Dictionary of Occupational Titles)

- Class 1 No limitation of functional capacity; capable of heave work* No restrictions (0-10% limitation)
- Class 2 Medium manual activity* (15-30% limitation)
- Class 3 Slight limitation of functional capacity; capable of light work* (35-55%limitation)
- Class 4 Moderate limitation of functional capacity; capable of clerical (sedentary*) activity (60-70%limitation)
- Class 5 Severe limitation of functional capacity; incapable of minimal (sedentary*) activity (75-100%limitation)
- Remarks:

4. MENTAL/NERVOUS IMPAIRMENT (If Applicable)

a) Please define "stress" as it applies to this patient.

b) What stress and problems in interpersonal relations has patient had on job?

- Class 1 Patient is able to function under stress and engages in interpersonal relations (No limitations)
 - Class 2 Patient is able to function in most stress situations and engage in most interpersonal relations (Slight limitations)
 - Class 3 Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (Moderate limitations)
 - Class 4 Patient is unable to engage in stress situations /engage in interpersonal relations (Marked limitations)
 - Class 5 Patient has significant loss of psychological, physiological, personal and social adjustment (Severe limitations)
 - Remarks:
-
-

Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? Yes No

5. PROGNOSIS

- a) Is patient totally or permanently disabled? ... Yes No If yes, what percentage of disability _____
- b) What duties of patients job is he/she incapable of performing?
-
-

c) Do you expect a fundamental or marked change in the future? Yes No
If yes, when will patient recover sufficiently to perform duties? __/__/__ 1Mo. 1-3 Mo. 3-6Mo. Never
If no, please explain.

6. REMARKS

Print Name (Attending Physician)

Degree/Specialty

()

Telephone

Street Address

City or Town

State or Province

Zip Code

/ /

Signature

Date