APPLICATION FOR L.U.141 RELIEF BENEFIT FUND

TO BE ELIGIBLE FOR BENEFITS, MEMBER DUES AND BENEFIT PAYMENTS MUST BE PAID FOR THE CURRENT MONTH THAT ILLNESS OR DISABILITY OCCURS

Member Full Name:_____Age:_____SSN:_____

Date Injury or Illness occurred: _____Card Number_____

What is the nature of the illness/injury?_____

If an injury, state when, where and how it occurred._____

_____

List first date you were unable to work because of the illness/injury._____

I hereby certify that the foregoing statements including and accompanying statements are to the best of my knowledge and belief, true correct and complete. I hereby authorize any physician or hospital to furnish and disclose all known facts concerning this disability.

Date:_____ Signature:_____

Street::_____

City:_____State:_____Zipcode:_____

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name: _____

Nature of illness or injury(describe complications if any:_____

_____

Date Of Treatments: Office:_____

Hospital: _____

This patient has been continuously disabled(unable to work) from:_____through:_____

Remarks:_____

_____

Date:_____ Signature of attending Physician:_____

Address:_____

_____

Phone: _____