

**WORKERS" COMP ELIGIBILITY HOURS ONLY**

GEMGroup LP  
Brandywine Corporate Center  
Suite 303 \* 650 Naamans Rd.  
Claymont, DE 19703

**DISABILITY STATEMENT OF CLAIM**

<b>Section 1 (To be completed by Member – Please print or type)</b>	
<b>MEMBER'S STATEMENT:</b>	<b>LOCAL UNION NO.</b>
<b>Insured's Name:</b>	<b>Social Security #</b>
<b>Date of Birth:</b>	
<b>Nature of Illness or Injury :</b>	
<b>If Accident (Describe) :</b>	
<b>How long were or will you be physically unable to work?</b>	
<b>From _____ Through _____</b>	
<b>Did this accident or sickness result from employment?</b> <input type="checkbox"/> <b>yes</b> <input type="checkbox"/> <b>no</b>	
<b>Name of last Employer preceding date of claim:</b>	
<b>Date Last Worked:</b>	

**Section 2 (to be completed by Attending Physician)**

<b>Diagnosis and concurrent conditions.</b>
<b>Date symptoms first appeared or accident happened.</b>
<b>Date patient first consulted you for this condition.</b>
<b>Patient ever had same or similar condition?    <input type="checkbox"/> <b>yes</b>    <input type="checkbox"/> <b>no</b>    If "yes" when _____</b>
<b>Patient still under your care for this condition    <input type="checkbox"/> <b>yes</b>    <input type="checkbox"/> <b>no</b></b>
<b>Patient was continuously disable (unable to work) From: _____ Thru: _____</b>
<b>If still disabled, date patient should be able to return to work. _____</b>
<b>PHYSICIANS NAME _____</b>
<b>EIN No. _____ Phone Number _____ Fax# _____</b>
<b>Physicians Address:</b>
<b>Physicians Signature: _____ Date: _____</b>

**Member's Signature \_\_\_\_\_ Date: \_\_\_\_\_**