

SHORT-TERM DISABILITY Form to be Completed and Returned to:
OHIO LABORERS' DISTRICT COUNCIL – OHIO CONTRACTORS' ASSOCIATION INSURANCE FUND
 800 Hillside Road • Westerville, OH 43081-3302
 Tel: (614) 898-9006 or (800) 236-6437 • Fax: (614) 898-9176

INSTRUCTIONS:

1. Member's Statement must be completed in detail, signed and dated by member.
2. Disabling Physician's Statement must be completed, signed and dated by physician.
3. If Workers' Compensation claim, no monetary benefit available, but complete form and include copies of approval letter from Bureau of Workers' Compensation for Disability Credit Hours only.
4. ***This is a taxable benefit. If you do not complete and submit a W-4 with this form, federal taxes will be withheld from your Short-Term Disability benefit at a standard withholding of Single with Zero Allowances.*** You should contact the OLFBP Fund Office to get federal (W-4) and state tax forms if interested.

MEMBER'S STATEMENT:

Member's Name		Social Security Number	Telephone Number
Home Address		City and State	Zip Code
Date of Birth	Nature of Sickness or Injury		Date Accident or Sickness Began
Last Date Worked	Date Returned to Work	Is Injury or Sickness Work Related? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Injured, How and Where did Accident Happen?			
Member's Signature		Date Completed	

DISABLING PHYSICIAN'S STATEMENT:

Diagnosis of Disabling Condition (ICD-9 Code)		
Should this claim be filed with Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date First Consulted for This Condition	
Patient was continuously Totally Disabled (Unable to Work) From _____ Thru _____	If Still Disabled, Approximate Date Patient Should Be Able to Return to Work Date Required _____	
Physician's Name (print)	Physician's Signature	Date Completed
Address	Phone #	Fax #