PHONE: (800) 499-8121
FAX: (323) 728-2982

Los Angeles Machinist Benefit Trust

6801 East Washington Blvd., City of Commerce, CA 90040

Disability Extension Form (DEOB)

Employer: _____ Home Phone # ( ) _____

PART I – To be completed by INSURED EMPLOYEE (Each question must be fully answered)

(1) Name _____ (2) Date of Birth _____

Street or Box _____ Social Security # _____

City, State, Zip _____ (3) Last date of work before disability _____

(4) Nature of Disability: _____ Injury? ❑ Illness? ❑

(5) It happened: Date _____ At work? _____ It ended (or is expected to end): _____

Time _____ At home? _____ Date _____

(6) How did it happen? _____

(7) Was it caused by your work? _____

(8) Have you filed for Worker's Compensation? _____ (9) If not, do you intend to file? _____

(10) Have you been disabled from a similar accident or sickness in the last five years? _____

(11) If so, did you receive Worker's Compensation for the previous disability? _____

AUTHORIZATION: **I hereby authorize any physicion, hospital, clinic, pharmacy, insurance company or other organization, governmental agency, institution, person, or my employer, that has any records or knowledge of me or my health, to give to Los Angeles Machinist Benefit Trust any and all information about me with reference to my health, and medical history, any benefits paid or payable, any hospitalization, advice, diagnosis, treatment, disease or ailment and my employment, education, training and job experience.** ***A photographic copy of this authorization shall be as valid as the original.***

I certify the above answers ate true and complete to the best ofmy knowledge and belief.

Dated _____ Mr. ❑, Mrs. ❑, Miss ❑ _____

Signature – Please Do Not Print

PART II – ATTENDING PHYSICIAN'S (Group Insurance – Form will be returned for unanswered questions)

(1) Nature of illness ❑ Injury ❑ (Describe complications, if any) _____

(2) If pregnancy, expected date of confinement _____

(3) Was this sickness or injury caused by patient's employment? Yes ❑ No ❑ Did your office complete a Worker's Compensation claim

Was it aggravated by patient's employment? Yes ❑ No ❑ for this disability? Yes ❑ No ❑

If "Yes" explain _____

(4) Nature of surgical or obstetrical procedure, if any (describe fully) _____

(5) Date performed _____, 20 _____

(6) Give dates of treatment consultation Other consultations during this period of disability

Office _____

Home _____

(7) If hospital confined, date admitted _____ date released _____

Name of Hospital _____

(8) The patient has been continuously disabled (unabled to work) from _____, 20_____ through _____, 20_____

If still disabled, when should patient be able to return to work? _____, 20_____

(9) Remarks: _____

Dated _____ Signed _____

Name _____

Address _____

Tel. No. ( ) _____

Return to: **Los Angeles Machinist Benefit Trust**
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