Operating Engineers Local 825 Fund Service Facilities

65 Springfield Avenue, Second Floor
Springfield, New Jersey 07081
(973) 671-6800

Pre-Cert and PPO
(800) 677-3237

Date:_____

Member:_____

Member ID#_____

Date of Accident/Illness_____

From:_____

Dear Member:
We would appreciate your prompt attention to the items checked below:

☐ Please have the attached form completed in its entirety. We need the original form returned to us in order to process your claim.

☐ Since our disability plan is a supplemental one, it is necessary that you provide us payment detail information. Please submit photocopies of your weekly state or private plan disability or worker's compensation check. You can fax this information to us at 973-629-1587.

☐ If your disability claim is determined to be eligible through the NJ State Plan, you will need to provide us with the payment detail page of the ABSTRACT. There are 2 ways to gather this:

1. For **Disability While Employed**, please call the Temporary Disability Benefits office at 609-292-7060 or access through the internet with the following steps:

   Google – NJ Temporary Disability – Click on "Web Services." Click on "Access Web Inquiry" and create a new user name and password to view your claim. Once you enter and view your claim, you will be able to print a payment detail page.

2. For **Disability During Unemployment**, please call 609-292-3842 to request and have an ABSTRACT mailed to you. This is the only way to receive the abstract necessary to process your application.

3. For **New York State Disability** please contact 877-632-4996, or website www.wcb.ny.gov for filing instructions and instructions on how to obtain payment detail information.

Please Note: A new abstract needs to be submitted every time you are paid from the State in order to process your supplemental disability benefits.

OPERATING ENGINEERS LOCAL 825 WELFARE FUND

ACCIDENT & SICKNESS CLAIM FORM

65 Springfield Avenue, Second Floor Springfield, NJ 07081 • 973-671-6800

CLAIMANTS STATEMENT

Full name Mr. Of Insured Mrs. Miss	Social Security No.	Date of Birth - M/D/YEAR
Address of Insured _____ House Number City State Zip		
If accident occurred, give date and time:	Did the sickness or injury arise out of the Insured's employment? Y N	Insured's phone number:
First day Insured was unable to work because of disability:	Date Insured was first treated by a physician in present disability:	If recovery has occurred, give date:
Date:	Insured's Signature	

ATTENDING PHYSICIAN/GROUP STATEMENT

Patient's Name & Address			Age
Diagnosis and Concurrent Conditions (If Fracture or Dislocation, Describe Nature and Location)			
Is condition due to injury or sickness arising out of patient's employment:	Y N	If "YES" explain:	
Is condition due to pregnancy?	Y N	If "YES" what was approximate date of commencement of pregnancy?	Date
Nature of Surgical or Obstetrical Procedure, if any (describe fully). Date Performed:			
Give dates of other medical (non-surgical) treatment if any.	Office _____ Home _____ Hospital _____		
Is patient still under your care for this condition? If "NO" give date your services terminated.	Y N	Date	
How long was or will patient be continuously totally disabled (Unable to work)? From _____ Thru _____			
Date: Physician Degree Phone			
Complete Address			
Physician's Signature Federal Tax ID Number			

Please have this form completed in its entirety