Short Term/Weekly Disability Form

PATIENT NAME: _____ I.D. Number: _____

PATIENT PHONE: _____ PATIENT D.O.B. _____

This form is to be completed and signed by the Attending Physician. Form is to be completed by an M.D. or D.O. (Medical Doctor or Doctor of Osteopathy.) The form can be mailed or faxed (**918.480.4899**) to the PIBF office for processing. The weekly disability benefit is available to active PIBF members during periods of total disability (unable to perform any type of work) and is payable for a maximum of 26 weeks. ***This is not an automatic benefit.*** Please refer to the PIBF Summary Plan Description for complete information regarding this or any other benefit provided by the Pipeline Industry Benefit Fund.

A new form is to be completed for each payment period.

ICD-10 Diagnosis Code and Description:_____

Disability is a result of: ☐ Illness ☐ Injury

Date of first treatment: _____ Date of most recent treatment: _____

The patient has been continuously disabled (unable to work) from: _____ through _____

☐ Estimated Return to work date: _____ ☐ Released/Return to Work Date _____

Physician Name: _____ Address: _____

City _____ State _____ Zip _____ Phone _____

Physician's Signature _____ **Date:** _____
(Attending Physician, including professional title)

A new form is to be completed for each payment period.
Please note: Payment cannot be issued beyond the date the physician signs this form.

PIBF Office Use Only:

From: _____ Through _____
Days: _____ $ _____

PIPELINE INDUSTRY BENEFIT FUND PHONE: 918.280.4800 FAX: 918.280.4899
P.O. Box 470950, Tulsa, OK 74147-0950

Renée E. Vause, Director