



# Industrial Disease - Claim Form

PLEASE COMPLETE IN BLOCK CAPITALS.

Name:

Date Of Birth:

Address:

National Insurance Number:

Telephone Number:

Period of Union Membership:

Years	Months
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Occupation:

Time worked in current occupation:

Years	Months
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Date last worked:

Previous Occupation:

Employer:

Time with present employer:

Years	Months
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Previous Employer:

Time with previous employer:

Years	Months
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Name and Address of Doctor:

Has claim for Disablement Benefit been made: YES/NO.

If YES, state date claim for Disablement Benefit began:

Nature of Illness:

Other Comments:

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## For Head Office Use Only:

M.B. Assessment:

Disablement Benefit:

Membership Number:

