

FILE NAME: Keene (KNE)

DATE: September 12, 1968

DOC#: KNE007

DOCUMENT DESCRIPTION: 1968 Sept 12 Insurance claim for Henry Carroll



a mutual life insurance company

AE

CLAIM FOR MONTHLY INCOME ACCIDENT AND SICKNESS BENEFITS

GROUP INSURANCE

EMPLOYER'S STATEMENT

Name of Employee: Henry Carroll						Policy Number: 7250 & 60-14149		Certificate Number: V-11	
Date entered your employ: Month 8 Day 1 Year 46			Date of certificate: Month 7 Day 1 Year 61			Date of latest increase, if any, in amount of Monthly Income Benefit. If no increase, state "None": Month _____ Day _____ Year _____			
Employee's Occupation: Work Lift Operator			Normal earnings prior to this disability (include bonus, overtime, etc.): \$ _____ Why: ☐ Mthly. ☐ Ann. ☐			Amount of Monthly Income Benefit for which Employee is insured: \$ _____			
Date Employee was first absent from work in present disability: Month 9 Day 12 Year 66			If Employee recovered, what was last date of actual disability: Month _____ Day _____ Year _____			Date work was resumed: Month _____ Day _____ Year _____			
Was Employees certificate in force when this disability commenced? If "No" please explain under "Remarks" ☒									
Was Employee actively engaged in work on a full time basis when this disability commenced? If "No" please explain under "Remarks" ☒									
Is disability due to sickness or injury arising out of any employment for wage or profit? If "Yes" please explain under "Remarks" ☐									
To your knowledge, is Employee receiving or is he entitled to receive benefits from any other source(s) because of this absence? If "Yes" please explain under "Remarks" ☐									
Remarks: _____									
Date _____ Employer: Baldwin-Khrst-Hill, Inc. By _____									

EMPLOYEE'S STATEMENT

Name of Employee: Henry Carroll			Date of Birth: Month 10 Day 11 Year 11		
No. 223 Street Brook Street			City or Town Bryn Mawr State Pa.		
Nature of sickness or injury			asthma of lung mild coronary heart disease		
Date first treated for this sickness or injury			Month 9 Day 10 Year 66		
If due to injury, give date of accident			Month _____ Day _____ Year _____		
If due to injury, where and how did accident occur?			_____		
On what date were you first unable to work because of this disability?			Month 9 Day 10 Year 66		
On what date were you first able to return to work?			Month _____ Day _____ Year _____		
If total disability has not ended, when do you expect it to end?			Month _____ Day _____ Year _____		
Names of hospitals and dates of confinement for this sickness or injury			The Bryn Mawr Hospital From Month 9 Day 10 Year 66 To Month 9 Day 15 Year 66 The Bryn Mawr Hospital From Month 9 Day 16 Year 66 To Month 10 Day 15 Year 66		
Names and addresses of all physicians consulted for this sickness or injury			Dr. E. H. Marshall 902 Pine St. Phila. Pa. March 1966 Dr. Harold Robinson Bryn Mawr Hosp. 9-16-66		
Are you entitled to benefits from any of the sources named below or any other source because of this disability or period of absence? Yes No					
Workmen's Compensation ☒ Yes ☐ No		Health or Welfare Plan ☐ Yes ☐ No		Any State, Provincial or Federal Agency ☐ Yes ☐ No	
Social Security ☐ Yes ☐ No		Salary Continuance Plan ☐ Yes ☐ No		Other source (give name below) ☐ Yes ☐ No	
Retirement or Pension Plan ☐ Yes ☐ No		Any Individual Insurance Policy ☐ Yes ☐ No			

If you are receiving or intend to claim benefits from any of the above sources, please furnish the following particulars:

Name of source	Amount of Benefits	How payable (Lump sum, weekly, monthly, etc.)	Name of source	Amount of Benefits	How payable (Lump sum, weekly, monthly, etc.)