

79
PAUL A. DAVIS, M.D.
INDUSTRIAL SURGEON

5034 WEST ROOSEVELT ROAD
CHICAGO 50, ILLINOIS

PHONES: AUSTIN 7-0758 & 7-0759

DATE August 11, 1969

NAME OF EMPLOYEE John Blano

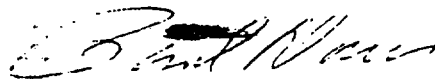
NAME OF COMPANY Victor-Dana

ACCEPTED ☐

REJECTED ☐

REMARKS

Able to return to work as per instructions of
Dr. Veverka until further notice.



Paul A. Davis, M.D.

VPD-189-0002408

DANA-287

Group Health Insurance Benefits

3 CASUALTY

TO BE COMPLETED BY THE EMPLOYEE

(Be sure to complete each item to avoid a delay in the payment of your claim.)

NAME John Blaho DATE OF BIRTH 7-30-09 SEX ☒ M ☐ F

First Name Middle Initial Last Name

HOME ADDRESS 2240 OAK PARK AVE Berwyn, IL 60402 TELEPHONE 484-8513

No. Street City State Zip Code

EMPLOYER VICTOR GASKET Division YOUR OCCUPATION Asbestos operator

EMPLOYER'S ADDRESS 5750 Roosevelt Chicago, Illinois

Street City State

IS THIS CLAIM FOR A DEPENDENT? YES ☐ NO ☒ Date of Birth _____ Married YES ☐ NO ☐

If Yes, Give Name _____ Relationship _____

HAVE YOU COMPLETED A STATEMENT OF CLAIM PREVIOUSLY FOR THIS ILLNESS? YES ☐ NO ☒

If Yes, Do Not Complete Remainder of Form Except for Signature.

DO YOU HAVE MORE THAN ONE EMPLOYER? YES ☐ NO ☒

If Yes, Give His Name _____

Address _____

No. Street City State

DO YOU HAVE OTHER FAMILY MEMBERS EMPLOYED? YES ☒ NO ☐

If Yes, Give Name John Blaho Relationship Son

Name and Address of Employer Victor Gasket Division

NATURE OF ILLNESS Difficulty Breathing DATE OF FIRST TREATMENT 6-10-69

IS THIS CLAIM BASED ON AN ACCIDENT? YES ☐ NO ☒

If Yes, Give Date _____ and Time _____ A.M. ☐ P.M. ☐

Where Did Accident Occur? _____

How Did Accident Happen? _____

ARE ANY OF THE ILLNESSES OR INJURIES FOR WHICH CLAIM IS BEING MADE RELATED TO EMPLOYMENT? YES ☐ NO ☒

ARE YOU OR ANY OF YOUR FAMILY MEMBERS COVERED THROUGH ANY OTHER PLAN WHICH PROVIDES MEDICAL BENEFITS OR SERVICES? YES ☐ NO ☒

If Yes, Give Name and Address of Organization Providing Services _____

I hereby authorize any insurance company, prepayment organization, employer, hospital, or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services.

SIGNATURE OF OTHER FAMILY MEMBER WHOSE INSURANCE COVERS THIS INDIVIDUAL _____

I hereby authorize any insurance company, prepayment organization, employer, hospital, or physician, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I certify that the information by me in support of this claim is true and correct.

DATE 6/25/69 SIGNATURE OF EMPLOYEE John Blaho