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: Mr. Mrs. Miss — Henry Carroll

Policy Number: 7250 & GO-14149 — Certificate Number: V-11

Date entered your employ: Month 8 | Day 1 | Year 46

Date of birth: Month 7 | Day 1 | Year 61

Date of increase, if any, in amount of Monthly Income Benefit. If no increase, state "None": Month | Day | Y

Employee's Occupation: Fork Lift Operator

Normal earnings prior to this disability (exclude bonus, overtime, etc.) $ _____ Wkly. ☐ 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

	Yes	No
Was Employee 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-Ehret-Hill, Inc. By _____

EMPLOYEE'S STATEMENT

Name of Employee: Mr. Mrs. Miss — Henry Carroll

Date of Birth: Month 10 | Day 11 | Year 1[illegible]

No. 223 Street Brook Street City or Town Bryn Mawr State Pa.

Nature of sickness or injury	asbestosis of lung mild coronary heart disease
Date first treated for this sickness or injury	9-60 / / 9-10-66 (Month / Day / Year)
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?	9 / 10 / 66 (Month / Day / Year)
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 1960 To 9 weeks The Bryn Mawr Hospital From 9-16-66 To 10-15-66
Names and addresses of all physicians consulted for this sickness or injury	NAME: Dr E. W. Marshall ADDRESS: 902 Pine St. Phila. DATE FIRST TREAT.: March 196 Dr. Hamilton Parkinson 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		Yes	No		Yes	No
Workmen's Compensation	☐	☒	Health or Welfare Plan	☐	☐	Any State, Provincial or Federal Agency	☐	☐
Social Security	☐	☐	Salary Continuance Plan	☐	☐	Other source (give name below)		
Retirement or Pension Plan	☐	☐	Any Individual Insurance Policy	☐	☐			

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, wkly, mthly, etc.)	Name of source	Amount of Benefits	How payable (lump sum, wkly, mthly, etc.)
[illegible]	[illegible]	[illegible]			