ENT OF CLAIM
GROUP POLICY 17300-G

ACCIDENT AND SICKNESS WEEKLY DISABILITY BENEFITS

Loc. Code 51

Claim No.

Check If Monthly Paid ☐

TO BE COMPLETED BY WESTINGHOUSE

26968 / Dept. No. / Empl. No.

Employe Mr. / Mrs. / Miss Thomas J. Mitchell (Initials / Last)

186-18-0797 Soc. Sec. No.

211 Brookline Blvd. (No / Street)

Havertown, Pa. 19083 (City / State / Zip)

1. Last day worked _____ 19 _____ Weekly Benefits $ _____

2. Effective date of coverage: Employe 12/1/68 Benefit Due Date _____ 19 _____

APPROVED BY _____ 19 _____

MAILING ADDRESS
WESTINGHOUSE ELECTRIC CORPORATION
LESTER BRANCH P.O. BOX 9175
PHILADELPHIA, PENNA. 19113
ATT. IND.-REL. DISABILITY BENEFITS

ISSUED BY A. McElhenney 9-9 19 77

TO BE COMPLETED BY THE EMPLOYE

PENGAD-Bayonne,N.J.
PLAINTIFF'S EXHIBIT
WH-899

1. Date you were first disabled by this sickness or injury 8-28 19 77

2. If you were Hospitalized, as a bed patient, answer the following:

(a) Name and Address of Hospital Fitzgerald-Mercy

(b) Date Admitted 8/28 19 77 at ____ Hour {am / pm} (c) Date Discharged 9/3 19 77 at ____ Hour {am / pm}

3. Was this disability due to an accident? Yes ☐ No ☐ If "Yes," answer the following:

(a) When did the accident happen? Date ____ 19 ____ at ____ Hour {am / pm}

(b) Give a brief description of the accident and where it happened _____

4. Vacation days still due this year _____

5. Give any information which might assist the Company in the consideration of this claim _____

6. Dept. No. 9222 Empl. No. 26968 Age 53 Home Phone No. None

I certify that in applying for accident and sickness insurance I am totally disabled and unable to work for either myself or any company and will return to work as soon as possible.
I further understand that falsification of information could result in termination or recovery of all money paid or termination of my employment.

Employe Thomas J. Mitchell (Signature / Date)

WESTINGHOUSE FORM 30692 PGD

28006469

Produced 3/93

7222-26760 Service Date: 5-14-57

Pipefitter B

TO BE COMPLETED BY THE PHYSICIAN ATTENDING

PROPRIETARY

ame of patient Thomas J. Mitchell Age 53

) Date of first treatment for this sickness or injury 8/22 19 77

) Date of last treatment 9/19 19 77

agnosis Silicosis (Asbestosis), right lung; possible carcinoma of right upper lobe

surgery was performed or is contemplated, give the nature and date Bronchoscopy on 8/31/77 by Dr. Steven E. Friedman

ie patient was physically unable to work from 8/22 19 77

nswer (a) or (b) whichever applies –

(a) The patient was able to return to work _____ 19 ____

(b) The patient may be able to resume work 10/15 19 77 YOUR BEST ESTIMATE!

this disability is the result of the patient's occupation, explain fully Questionable if x-ray changes are due to asbestos exposure

PLEASE COMPLETE, SIGN, DATE AND MAIL IMMEDIATELY!

Signature [signature] M.D.
Attending Physician Date

Name (please print) Robert G. Trout, M.D.

Address The Glover Clinic
Suite 202
3910 Powelton Avenue
Phila., Pa. 19104

Office Phone No. 387-5950

AYMENTS TO OUR EMPLOYE CANNOT BE MADE VITHOUT THIS FORM.

MEDICAL DEPARTMENT REVIEW

Mr. Whittington
For your information only - According to Mr. Hanley in Pittsburgh we should not open up investigation unless it were under the circumstances of a claim being filed against us.

osis:

Date:

ks:

A. McElhenney
9-29-77

RETURN INTERVIEW SCHEDULED:

Date: _____

Time: _____ a.m. _____ p.m.

Notice Mailed _____
Date

PROPRIETARY

28006468

Produced 3/93