



CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND

12 E. Erie Street, Chicago, IL 60611 (312)787-9455, Option #3



STUDENT VERIFICATION FORM FOR MEDICALLY NECESSARY LEAVE OF ABSENCE OR OTHER CHANGE IN ENROLLMENT

For Full-Time Students on a Medically Necessary Leave of Absence or Change of Enrollment (Age 19-22)

PART I: SCHOOL ATTENDANCE VERIFICATION

TO BE COMPLETED BY PARTICIPANT:

1. PARTICIPANT'S NAME: _____ SSN or UID: _____
 DEPENDENT CHILD'S/STUDENT'S NAME: _____ DATE OF BIRTH: _____
 DEPENDENT'S SCHOOL: _____

2. My child named above is an eligible dependent under the Plan and is on (a) a medically necessary leave of absence or (b) part-time student status (circle one) from the school identified above due to a serious injury or illness. Enter the date the leave and/or part-time status began: _____.

3. Prior to such illness, the child was or was not (circle one) covered under the Plan as a full-time student.

4. _____

 Signature of Participant Date

TO BE COMPLETED BY DEPENDENT:

1. DEPENDENT'S NAME: _____ SSN: _____

2. DATE OF BIRTH: _____

3. DEPENDENT'S ADDRESS: _____

4. I authorize the School Representative named below to release the requested enrollment information to the Chicago Regional Council of Carpenters Welfare Plan.

Signature of Dependent Date

TO BE COMPLETED BY SCHOOL REPRESENTATIVE:

1. The Student named above was a full-time student attending this institution until _____. (enter date)
 The Student named above (a) is no longer enrolled or (b) became a part-time student (circle one) as of _____. (enter date)

2. START DATE OF STUDENT'S LATEST ENROLLMENT TERM: _____ END DATE OF TERM: _____

SCHOOL: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: () _____ EXTENSION: _____

3. _____

Signature of School Representative Title Date

PART I OF THE VERIFICATION FORM MUST BE RETURNED WITH ANY OTHER REQUESTED STUDENT DOCUMENTATION TO THE FUND OFFICE AT THE ADDRESS ABOVE



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PART II: TREATING PHYSICIAN CERTIFICATION

TO BE COMPLETED BY PARTICIPANT:
1. PARTICIPANT'S NAME: _____ SSN or UID: _____
DEPENDENT CHILD'S/STUDENT'S NAME: _____ DATE OF BIRTH: _____
DEPENDENT'S SCHOOL: _____
2. My child named above is an eligible dependent under the Plan and is on (a) a medically necessary leave of absence or (b) part-time student status (circle one) from the school identified above due to a serious injury or illness. Enter the date the leave and/or part-time status began: _____
3. Prior to such illness, the child was or was not (circle one) covered under the Plan as a full-time student.
4. _____
Signature of Participant Date

TO BE COMPLETED BY DEPENDENT:
Please complete the attached PART III: Authorization for the Release of Medical Information.

PHYSICIAN'S CERTIFICATION TO BE COMPLETED BY TREATING PHYSICIAN :
1. I am a treating physician of the Dependent Child named above: Yes _____ No _____
The Dependent Child named above is suffering from the following serious illness or injury (diagnosis):

(if required attach additional information).
Enter Approximate Date of Onset: _____
The serious illness or injury designated above caused a
(a) leave of absence from school or (b) reduction to part-time status (circle one) which is medically necessary.
The leave or absence or part-time status began on _____.
It is expected that the medically necessary leave of absence will last through _____.
2. PHYSICIAN NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: () _____ EXTENSION: _____
3. _____
Signature of Treating Physician Date

PART II OF THE VERIFICATION FORM MUST BE RETURNED WITH ANY OTHER REQUESTED MEDICAL DOCUMENTATION TO THE FUND OFFICE AT THE ADDRESS ABOVE



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PART III: Authorization for Release of Medical Information To Be Completed by Dependent Child

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize the provider(s) named in Item 1 of this Authorization to disclose my health information to the Chicago Regional Council of Carpenters Welfare Fund (the "Fund") as described in this authorization.

(1) Physician's name: _____
Last First Middle
Address: _____
Telephone Number (____) _____ Fax Number (____) _____
Date of First Treatment: _____ Last Treatment: _____

(2) The provider(s) described in Item 1 of this Authorization may disclose to the Chicago Regional Council of Carpenters Welfare Plan all the information it holds relating to my serious illness or injury described in Physician's Certification on Part II the Verification Form.

(3) I am requesting that my information be disclosed for the purpose of allowing the Fund to evaluate my entitlement to continued enrollment under the Fund due to a medically necessary leave of absence or other enrollment change from my school due to a serious illness or injury.

The nature of the serious illness or injury to which this Authorization applies is as follows:

(4) Expiration of Authorization. This authorization will expire: [choose and complete one]:
_____ When a final decision is made on my eligibility for continued enrollment by the _____ Fund.
_____ On the date my coverage under the Fund terminates.
_____ Other specific date: _____
_____ Upon the occurrence of the following event: _____.

I understand that the expiration date or event must be related to me or related to the purpose of the use or disclosure (for example: "when my eligibility request for continued Plan enrollment is resolved").

(5) Right to Revoke: I understand that I have the right to revoke this authorization at any time by notifying the provider(s) described in Item 1 of this Authorization in writing. I understand that the revocation is only effective after it is received by the provider(s). I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation.

(6) Potential for Redisclosure: I understand that after the information described in (2) and (3) above is disclosed pursuant to this Authorization, federal law might not protect it, and the recipient might redisclose it.

(7) Right to Copy: I understand that I am entitled to receive a copy of this authorization.

**PART III: Authorization for Release of Medical Information (Page 2)
To Be Completed by Dependent Child**

(8) *Voluntary:* I understand that I am under no obligation to sign this form. I acknowledge that I am voluntarily signing this form to release my protected health information to the party I have designated.

(9) *Benefits Not Conditioned on Form:* I understand that the provider(s) described in Item 1 of this Authorization may not condition treatment on receipt of this authorization form.

I have had an opportunity to review and understand the contents of this form. By signing this form, I am confirming that it accurately reflects my wishes.

Dependent Child's Printed Name

Dependent Child's Signature

Dependent Child's Social Security Number

Date

Dependent Child's Address, City, State, Zip

Personal Representative Section

If a Personal Representative executes the form on behalf of the Individual, the Personal Representative warrants that he or she has the authority to sign this form on the basis of:

_____ A valid power of attorney for health care purposes (copy attached).

_____ A court order appointing the person as the dependent child's conservator or guardian (copy attached).

_____ An unemancipated minor child's parent.

_____ Other: _____

NOTE: This authorization will not be valid unless you provide all of the information requested.

PART III OF THE VERIFICATION FORM MUST BE RETURNED WITH ANY OTHER REQUESTED MEDICAL DOCUMENTATION TO THE FUND OFFICE AT THE ADDRESS ABOVE