



Instructions for Completing the Weekly Disability Claim Form

1. **Determine if you are eligible to file a Weekly Disability Claim.** If you are disabled during an Insurance Quarter and you are eligible for Welfare insurance benefits, you may be entitled to weekly disability benefits. The benefits include a weekly benefit check and credit of welfare disability hours. Work related injuries are not eligible for the weekly benefit check, but may be eligible for credit of welfare hours. The carpenter **must** be under the active care of a physician during the **entire period of disability**. The weekly disability benefit is not available to a carpenter on the Low Cost Medical Plan, nor is it available to a carpenter's spouse or dependent child.
2. **Complete the Disability Claim form in its entirety.** Print clearly in blue or black ink and answer all questions to Part 1, Part 2 and Part 3. Have your attending physician complete Part 4. If the form is not legible, if a question is left unanswered or the form has not been signed, it will be returned to you for completion. The Weekly Disability Claim form is not valid unless it is signed and dated by you and your attending physician. Incomplete forms will be returned for completion and will result in a delay of your benefits.
3. **Mail or fax the completed Weekly Disability Claim form to:**

Via Mail: Chicago Regional Council of Carpenters Welfare Fund
Attn: Participant Services Dept.
12 East Erie Street
Chicago, IL 60611

Via Fax: 312-951-1515

If faxing: The **original** Weekly Disability Claim form **must** also be mailed to the Fund Office. Please be advised that your benefit check will be held and/or credit of hours will not get posted until the Fund Office receives the original document.

4. **What happens next?** Disability checks and/or credit of welfare hours are issued within five (5) business days of the Fund Office's receipt of the **original** Weekly Disability Claim form. Disability checks are issued on Thursdays.
5. **What must I do to maintain my benefit?** You will be required to have your attending physician complete a Weekly Disability Recertification Claim form verifying you continue to be under the care of a physician and you continue to remain disabled. The Fund Office will send to you the recertification form when required.
6. **Questions?** Should you have questions regarding completing this form or your eligibility for this benefit, please contact the Welfare Fund at 312-787-9455, phone option 3. Any one of the Participant Services Representative can assist you Monday through Friday between the hours of 8:00 a.m. and 4:30 p.m.

Note:

- ✓ **For Workman's Compensation Cases Only:** If you are filing for credit of disability welfare hours for a work related injury or illness that occurred more than 12 weeks ago, it will be necessary for you to provide copies of all your Workman's Compensation loss wage TTD check stubs. In lieu of TTD check stubs, you may also submit a ledger or benefit summary letter from the worker's compensation carrier that details all loss wage benefits paid to you. Please include this information along with your completed Weekly Disability Claim form.



CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND

12 EAST ERIE STREET • CHICAGO, IL 60611

(312) 787-9455, OPTION 3

FAX: 312-951-1515



WEEKLY DISABILITY CLAIM FORM

(Print Clearly)

CLAIM NO. _____

Instructions: The participant must complete Parts 1, 2 & 3. Your physician must complete Part 4. Return the completed form (by mail or fax) to the Fund Office. If you fax, please mail the original to the Fund Office. Failure to complete this form in full may result in a delay of payment.

Part 1 – Participant Information						
1. Participant's Last Name	First	Middle Initial	2. Date of Birth	3. Soc. Sec. Number or BCBS I.D. Number		
4. Participant's Home Address			5. City	6. State	7. Zip Code	
8. Telephone Number ()	9. Cell Phone Number ()		10. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		11. Email Address	
Part 2 – Employer Information						
1. Employer's Name			2. Employer's Phone Number ()			
3. Employer's Address		4. City	5. State	6. Zip	7. Date Hired / /	
Part 3 – Details of Your Illness, Injury or Accident						
1. Date illness or accident occurred / /		2. Date of first treatment for illness or injury / /		3. Were you first treated in the Emergency Room? <input type="checkbox"/> Yes <input type="checkbox"/> No		
4. Is the illness or injury due to work? <input type="checkbox"/> Yes <input type="checkbox"/> No		5. If you suffered an injury, was it due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		6. If yes, provide date of accident / /		7. Time of accident : a.m. or p.m.
8. When, where & how did the illness, injury or accident occur?						
9. Give history (details) of the illness, injury or accident						
10. Provide a list of injuries and/or illnesses						
11. Have you filed or do you intend to file this claim under Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No			12. If no, do you plan to seek reimbursement from another party? <input type="checkbox"/> Yes <input type="checkbox"/> No - If yes, answer questions 13, 14 & 15			
13. Provide name of party responsible for injury/accident		14. Address, City, State & Zip			15. Phone Number ()	
16. Have you been unable to work as a result of this illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		17. What was the first <u>full</u> day you were unable to work? / /		18. What was the <u>last</u> day that you actually worked? / /		
19. Have you resumed work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when: / /			20. Do you expect to resume work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when: / /			
21. If you are not filing a Worker's Compensation Claim, do you wish to file for a Weekly Disability Benefit? <input type="checkbox"/> Yes <input type="checkbox"/> No			22. If you have filed a Worker's Compensation claim, do you wish to file for Disability Credit Hours only? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<p>The above answers are true and correct to the best of my knowledge and belief. I understand that it is fraudulent for me or anyone to knowingly complete this form with false or misleading information or to knowingly omit important facts. I authorize any medical professional, hospital or other medical care institution, insurance support organization, pharmacy, government agency, insurance company, group policyholder, employer or benefit plan administrator to release to the Chicago Regional Council of Carpenters Welfare Fund (the "Welfare Fund"), or its representatives, any information concerning the medical advice, care or treatment provided to me, including but not limited to medical history, medical records from another provider, diagnosis, prognosis, symptoms and treatment of any physical or mental condition related to this application, and any employment-related information. I understand that such information will be used to evaluate my claim for benefits and that I, or my representative, will receive a copy of this information upon request. Any information received by the Welfare Fund pursuant to this authorization shall be maintained in accordance with applicable privacy laws. This authorization shall expire at the later of (i) one year from the date of your signature or (ii) termination of the period in which you are eligible for Weekly Disability benefits. You have the right to revoke this authorization at any time. A photographic copy of this authorization is as valid as the original. I understand that Weekly Disability benefits will not be paid until all sections of this form are completed by me and my medical doctor as indicated.</p> <p>In the event I collect Weekly Disability benefits as a result of an illness, accident or injury, I hereby authorize the Welfare Fund to release information of any weekly disability payments to the Chicago Regional Council of Carpenters Pension or Millmen Pension Funds (together, the "Pension Funds") as necessary to credit hours to my work history for use in calculation of my future pension benefits. If I apply and am approved for a Disability Pension, I understand that I cannot receive Weekly Disability benefits and a Disability Pension for the same period of time. I acknowledge that if I am approved for a Disability Pension, I will not be able to receive more than six (6) days of a Weekly Disability benefit in any month in which I receive my first monthly benefit under the Pension Plan. If my Disability Pension is approved and paid during the same period or portion of the period of my Weekly Disability benefit, I agree to reimburse the Welfare Fund for benefits paid up to the amount of my pension benefits. Recovery of such amount may be made through, but is not limited to, an offset or reduction of any future benefits you may be entitled to receive from the Welfare Fund or the Pension Funds.</p>						
(Claim not valid unless signed by Participant)						
23. Participant's Signature X			Date: / /			

Part 4 – To be Completed by Attending Physician

1. Patient's Name (Last) (First) (Middle Initial)		2. Patient's Soc. Sec. Number or BCBS I.D. Number		3. Patient's Date of Birth / /	
4. Nature of sickness or injury (describe complications, if any)					
5. Report of Services (If you have submitted a previous form for this patient, you need only show dates and service since last report)					
Date of Services	Place of Service	Description of Surgical or Medical Services Rendered		Procedure Code – If Used (If code other than CPT used, give name)	
6. Patient was continuously totally disabled (unable to perform duties of occupation) from <input type="checkbox"/> n/a or / / through / /			7. Patient was continuously partially disabled from <input type="checkbox"/> n/a or / / through / /		
8. Please state whether you are actively supervising the patient's care and, if so, the frequency of visits (e.g., weekly, monthly)					
9. If patient was partially disabled, please list restrictions, including weight restrictions					
10. Date patient is able to return to work / /			11. Is condition due to injury or sickness arising out of the patient's employment? <input type="checkbox"/> Yes <input type="checkbox"/> No		
12. For services related to hospitalization, give hospitalization dates Date Admitted: / / Date Discharged: / /					
13. Attending Physician's Name				14. Phone Number ()	
				15. Fax Number ()	
16. Attending Physician's Address		17. City		18. State	19. Zip
20. Signature of Physician		21. Physician's Tax Identification Number		22. Date Completed / /	