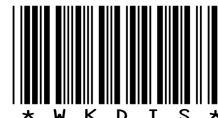
CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND

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: ☐ Male ☐ 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? ☐ Yes ☐ No	
4. Is the illness or injury due to work? ☐ Yes ☐ No	5. If you suffered an injury, was it due to an accident? ☐ Yes ☐ 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? ☐ Yes ☐ No	12. If no, do you plan to seek reimbursement from another party? ☐ Yes ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ No If yes, when: / /	20. Do you expect to resume work? ☐ Yes ☐ 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? ☐ Yes ☐ No	22. If you have filed a Worker's Compensation claim, do you wish to file for Disability Credit Hours only? ☐ Yes ☐ No

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.

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.

(Claim not valid unless signed by Participant)

23. **Participant's Signature X** Date: / /

NOTICE TO ALL PARTIES COMPLETING THIS FORM: It is fraudulent to fill out this form with information you know to be false or misleading or to knowingly omit important facts. Criminal and/or civil penalties can result from such an act.

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 ˇ n/a or / / through / /	7. Patient was continuously **partially** disabled from ˇ 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? ˇ Yes ˇ 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 / /

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