RETURN FULLY COMPLETED
DISABILITY FORM TO:

Local 731, I.B. of T. Welfare Funds

1000 Burr Ridge Pkwy ● Suite 301 ● Burr Ridge, IL 60527

INSTRUCTIONS: This Claim Form is to furnish the information needed to Service your Claim. Please answer **ALL** questions fully.

FOR CLAIM STATUS: CALL (630) 920-1939
FOR BENEFIT INFO: CALL (630) 887-4150

MEMBER INFORMATION

Name of Member _____ ID NO. _____ Date of Birth _____

Home Address _____

City_____ State _____ Zip Code_____ Telephone No. ( ) _____

Social Security No. _____ Occupation _____ Active ☐ Retire Date _____

Marital Status: Single _____ Married_____ Divorced _____ Separated _____ Widowed _____ Date of Social Security Award_____

*NOTE: If recently married or divorced indicate date(s) _____

OTHER INSURANCE INFORMATION NOTE: Attach copy of payment worksheet from other insurance or Medicare

Do you or your dependents have **ANY** other health insurance: Yes ☐ No ☐ If YES, please supply:

1) Name of the person insured _____Relationship to Employee: _____
2) Insured person's Social Security No. _____ Date of Birth _____ Policy No. _____
3) Insurance company name _____Telephone No. ( ) _____
4) Address, City, State, Zip _____

SICKNESS/INJURY INFORMATION *Required for all Claims*

This claim is for ☐ Self ☐ Spouse ☐ Dependent

Name of Patient _____Social Sec. No. _____ Date of Birth _____

Patient's Occupation. _____ Where Employed, or School, if Student _____

Address, City, State, Zip of Employer or School _____

Claim is for ☐ an accident ☐ a sickness

Briefly describe (for example: heart, fall, etc.) _____

Date accident occurred or sickness first began _____ Date first treated _____

If injured, detailed description of HOW and WHERE accident occurred _____

_____

Did injury or sickness arise in the course of ANY employment: ☐ Yes ☐ No

Have you or do you intend to file this claim under Worker's Compensation? ☐ Yes ☐ No

STATEMENT OF EMPLOYER: (To be completed BY EMPLOYER for weekly disability benefits)

1) Was employee in your active full-time employment when disability began? Yes ☐ No ☐ If No, please explain: _____

_____

2) Is disability the sole cause of this absence from work? Yes ☐ No ☐ If No, please explain: _____

_____

3) Total Disability (unable to do any work) from: _____ Returned to Work _____
(Month) (Day) (Year) (Month) (Day) (Year)

_____

4) If still disabled, when is Employee expected to return to work? _____
5) Is this disability the result of injury or disease arizing out of, or in the course of employment? Yes ☐ No ☐
If Yes, is the compensation claim being filed? Yes ☐ No ☐

DATE _____20 ____ Employer's Signature _____
(Title)

MEMBER'S SIGNATURE

I hereby certify the above statements are true and complete to the best of my knowledge and belief. I authorize the release, when requested by the Trustees or their representative of any facts and or related records concerning the injury, illness; or treatment (including mental/nervous and substance abuse) of myself or my dependents. A photocopy of this authorization shall be considered as effective and valid as the original.

Member's Signature **X** _____ Date _____

IMPORTANT:

HAVE YOU SIGNED THIS FORM AND ANSWERED ALL QUESTIONS?

DISABILITY CLAIM FORM - CONTINUED

1. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Authorize the Release of any Medical information Necessary to Process this Claim and Request Payment of MEDICARE/CHAMPUS Benefits Either to Myself or to the Party Who Accepts Assignment Below SIGNED DATE	**2.** I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW SIGNED (Insured or Authorized Person)

3. DATE OF:	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	4. DATE FIRST CONSULTED YOU FOR THIS CONDITION	**5.** HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ☐ NO ☐
6. DATE PATIENT ABLE TO RETURN TO WORK	7. DATES OF TOTAL DISABILITY FROM THROUGH		DATES OF PARTIAL DISABILITY FROM THROUGH
8. NAME OF REFERRING PHYSICIAN			**9.** FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
10. NAME & ADDRESS OF FACILITY WHERE SERVCES WERE RENDERED (If other than home or office)			**11.** WAS LABORATORY WORK PERFOMED OUTSIDE YOUR OFFICE? YES ☐ NO ☐ CHARGES

12. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, **RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE**

1.

2.

3.

4.

13. **A** DATE OF SERVICE	**B*** PLACE OF SERVICE	**C** FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY;)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	**D** DIAGNOSIS CODE	**E** CHARGES	**F**

14. SIGNATURE OF PHYSICIAN OR SUPPLIER	**15.** ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) YES ☐ NO ☐	**16.** TOTAL CHARGE	**17.** AMT PAID	**18.** BAL DUE
	19. YOUR SOCIAL SECURITY NO.	**20.** PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.		
21. YOUR PATIEN'S ACCOUNT NO.	**22.** YOUR EMPLOYER'S I.D. NO.	I.D. NO.		

* PLACE OF SERVICE CODES

1 --- (IH) --- INPATIENT HOSPITAL
2 --- (OH) --- OUTPATIENT HOSPITAL
3 --- (O) --- DOCTOR'S OFFICE
4 --- (H) --- PATIEN'S HOME
5 --- --- DAY CARE FACILITY (PSY)
6 --- --- NIGHT CARE FACILITY (PSY)
7 --- (NH) --- NURSING HOME
8 --- (SNF) --- SKILLED NURSING FACILITY
9 --- --- AMBULANCE
O --- (OL) --- OTHER LOCATIONS
A --- (IL) --- INDEPENDENT LABORATORY
B --- --- OTHER MEDICAL / SURGICAL FACILITY

LOCAL 731, I.B.OF T.

APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 6-74