



Chicago Regional Council of Carpenters Welfare Fund

Your Future — Our Focus

Instructions for Completing the Recertification Claim Form for Continued Illness or Injury Benefits

- 1. This form is required to be completed in order to continue or end your disability benefit. If this is your first time filing for disability for your present condition, you will need to complete the Claim Form for Illness or Injury Benefits. You cannot initiate a claim with this form. The Illness or Injury benefit plus credit of welfare hours is available only to a carpenter who is currently eligible for benefits and who is unable to work in covered employment due to a non-work related illness or injury. Work-related injuries are not eligible for a 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. This weekly benefit for Illness or Injury is not available to a carpenter on continuation coverage under COBRA, the Low Cost Medical Plan, nor is it available to a carpenter's spouse or dependent child.
2. Complete the Recertification Claim Form in its entirety. Print clearly in blue or black ink and answer all questions in Parts 1 and 2. Have your attending physician complete Part 3. 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 Recertification Claim Form must be signed and dated by you and your physician to be valid. Incomplete forms will be returned for completion and will result in delaying your benefit.
3. Mail, email or fax the completed Claim Form to:

Table with 3 columns: Mail, Email, Fax. Mail: Chicago Regional Council of Carpenters Welfare Fund, Attn: Weekly Disability Processing, 12 East Erie Street, 7th Floor, Chicago, IL 60611. Email: Disability@crccbenefts.org. Fax: 312-951-1515.

- 4. What is the typical timing on recertification requests? Generally, within 5-7 business days of the Plan's receipt of all documentation needed to process your Illness or Injury Recertification Claim form, the Plan will evaluate the information provided on the form to continue your disability benefit. Disability checks are issued and mailed every Thursday.
5. How do I apply for further disability benefits if I am disabled beyond the period certified by my doctor? If you continue to remain disabled you will be required to complete another Recertification Claim Form confirming that you continue to be under the care of a physician with verification from him or her that you continue to remain disabled. The Plan will send to you another recertification form when needed for completion. You may also download a form from the Fund's website at www.crcbnefts.org. Under "Health Plan," select "Forms". Scroll down to "Short Term Disability Claim-Recertification" form. Note that the Plan provides benefits for a maximum period of 52 weeks only.
6. Request for Medical Records. There may be instances when medical records are needed to substantiate your condition and determine your eligibility for, or a continuation of, Weekly Illness or Injury benefits. The Fund does not pay for medical records. It is your responsibility to provide and pay for such medical records when requested.
7. Questions? For any 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.



# CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND

12 East Erie Street • Chicago, IL 60611

Phone: (312) 787-9455, Option 3 • Fax: (312) 951-1515

Email: Disability@crccbenefts.org



## RECERTIFICATION CLAIM FORM FOR ILLNESS OR INJURY BENEFITS

(Print Clearly)

CLAIM NO. \_\_\_\_\_

**Instructions:** The participant must complete Part 1 and 2. The attending physician must complete Part 3. 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.

<b>Part 1 – To be completed by Participant</b>						
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	
12. If you are being treated by physicians other than the one completing this form, please provide their names and phone numbers below:						
12(a) Name:				Phone Number: (     )		
12(b) Name:				Phone Number: (     )		
<b>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.</b> (Claim not valid unless signed by Participant)						
13. Participant's Signature X				Date:		
<b>Part 2 – Authorization for Release of Information</b>						
<p>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'), its representative or entity acting on its behalf, 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. The information will be used to evaluate my claim for Weekly Disability Benefits. Any information obtained that is subject to applicable privacy laws will not be released by the Welfare Fund to any person or organization except to re-insuring companies, the Medical Information Bureau, Inc., my employer, group policyholder or other persons or organizations performing business or legal services in connection with my claim, or may be otherwise lawfully required or as I may further authorize.</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> <p>I understand that:</p> <ul style="list-style-type: none"> <li>• This authorization is voluntary and I may refuse to sign it.</li> <li>• I have the right to revoke this authorization at any time before its expiration date by sending a written notice to each entity that I previously authorized to disclose the information. The revocation will not have any effect on any actions the entity took before it received the revocation notice.</li> <li>• I am not required to sign this authorization as a condition to receiving treatment or payment for health care; enrolling in a health plan; or establishing eligibility for health benefits.</li> <li>• The information used or disclosed pursuant to this authorization may be re-disclosed by the receiving person or organization and, upon re-disclosure, may no longer be protected by federal privacy laws.</li> <li>• I, or my representative, will receive a copy of this information upon request. A photographic copy of this authorization is as valid as the original.</li> <li>• 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.</li> <li>• Weekly Disability benefits will not be paid until <b>all sections</b> of this form are completed by me and my medical doctor as indicated.</li> </ul>						
<b>Participant's or Representative's Signature</b>				Date:		
X						
Printed Name of Representative* (if applicable):				Relationship to Participant:		
*Enclose documentation demonstrating authority to act as Participant's Representative						

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.

**IF THE PHYSICIAN HAS INDICATED THAT YOU ARE ABLE BODIED TO WORK WITH RESTRICTIONS (LIGHT OR MODERATE DUTY), BUT THERE IS NO LIGHT DUTY AVAILABLE TO YOU; A CORROBORATIVE STATEMENT FROM THE EMPLOYER IS REQUIRED.**

**Part 3 – To be completed by the Attending Physician.**

1. Patient's Name (Last) (First) (Middle Initial)	2. Patient's BCBS I.D. Number CGO	3. Patient's Date of Birth
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4. Nature of sickness or injury (describe complications, if any)

**5. Report of Services. Include dates of service since initial period of disability, or the last Recertification period.**

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 has been <b>totally</b> disabled (unable to perform duties of occupation) From _____ through _____	7. Patient has been <b>partially</b> disabled: From _____ through _____
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8. Are you actively supervising the patient's care?     No.     Yes      Frequency of Appointments: \_\_\_\_\_  
(i.e., 2x per week, 1x per month)

Visit Dates (MM/DD/YYYY)		Has patient been referred to other physicians?	
Last:		Name	Specialty
Next:		Name	Specialty

Date Patient is able to return to work:            /            /             with some restrictions (complete section 9 below),  
 with no restrictions (select **Heavy work** in section 9)  
 Disability is permanent, and patient will not return to work.

9. Abilities and Limitations. Patient is able to complete:

**Heavy work** activity. No limitations of functional capacity

**Medium work** activity Exerting 20-50 pounds of force occasionally, and/or 10-25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly.

**Light work** activity. Exerting up to 20 pounds of force occasionally and/or up to 10 pounds of force frequently.

**Sedentary work** activity. Moderate limitation of functional capacity. Exerting up to 10 pounds of force occasionally. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time.

**No ability to work.** Patient is completely disabled. Severe limitation of functional capacity; incapable of minimal activity

**Other.** Please explain below.

\_\_\_\_\_

**10. Attending Physician**

Name	Specialty/Credentials	Phone Number: (    )
Address	Tax ID Number	Fax Number: (    )
Signature	Date	