



Your Future — Our Focus

Chicago Regional Council of Carpenters Welfare Fund

Instructions for Completing the Claim Form for Illness or Injury Benefits

- Determine if you are eligible to file a claim for Illness or Injury benefits.** If you become disabled during an Insurance Quarter for which you are eligible for Welfare insurance benefits, you may be entitled to file a claim for weekly Illness or Injury 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 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.*
- Complete the Claim Form in its entirety.** Print clearly in blue or black ink and answer all questions to Part 1, Part 2, Part 3 and Part 4. Have the physician who has disabled you complete Part 5. 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 Claim Form for Illness or Injury benefits 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.
- Mail, email or fax the completed Claim Form to:**
 - Via Mail: Chicago Regional Council of Carpenters Welfare Fund
Attn: Disability Processing
12 East Erie Street
Chicago, IL 60611
 - Via Email: Disability@crccbenefts.org
 - Via Fax: 312-951-1515
- When do payments start?** Generally disability checks and/or credit of welfare hours are issued within 5-15 business days of the Fund Office's receipt of all documentation needed to process the claim. Disability checks are issued on Thursdays.
- How to extend disability period beyond the initial request.** You will be required to have your attending physician complete a Recertification Claim Form for Illness or Injury benefits verifying that you continue to be under the care of a physician and you are still disabled. The Fund Office will send to you the recertification form when required. You may also download a form from the Fund's website at www.crccbenefts.org. Under "Health Plan," select "Forms". Scroll down to "Short Term Disability Claim-Recertification" form.
- Information about Federal Taxes.** We will not deduct Federal taxes unless you instruct us to. You are liable for the taxes on the benefits. We are required to send a report to your employer at the end of each calendar year showing your name, total amount of benefits paid to you, total amount withheld if any, and your social security number. If you want us to withhold tax, you may download a form from the Fund's website at www.crccbenefts.org. Under "Health Plan," select "Forms", scroll down to "Short Term Disability Claim Form" and click on "IRS Form W-4S."
- 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 Representatives can assist you Monday through Friday between the hours of 8:00 a.m. and 4:30 p.m.

Note: For Workers' 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 Workers' 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 Claim Form for weekly Illness or Injury benefits.



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



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CLAIM FORM FOR ILLNESS OR INJURY BENEFITS (Print Clearly)

Instructions: The participant must complete Parts 1 thru 4. Your physician(s) must complete Part 5. 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 Middle Initial		First	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. Did you receive any compensation from your employer, such as holiday/vacation/sick time, after you were deemed disabled by your physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what was the last paid date? _____						
By providing your email address above, you consent to the use of electronic communications in connection with this claim to the extent available and permissible by state law (which may include, but not limited to, claim correspondence or other materials that CRCC is, or may be, legally required to deliver to you.						
Part 2 – Employer Information						
1. Name of Last Employer				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 this disability		3. Were you first treated in the Emergency Room? <input type="checkbox"/> Yes <input type="checkbox"/> No		
4. How and where did the illness, injury or accident occur?						
5. Give history (details) of the illness, injury or accident						
6. Provide a list of conditions/symptoms related to this disability						
7. Is the illness or injury due to work? <input type="checkbox"/> Yes <input type="checkbox"/> No		8. If you suffered an injury, was it due to an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		9. If yes, provide date and time of accident / / , a.m. or p.m.		
10. Have you filed or do you intend to file this claim under Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No			11. If no, do you plan to seek reimbursement from another party? <input type="checkbox"/> Yes <input type="checkbox"/> No - If yes, answer questions 12, 13 & 14			
12. Provide name of party responsible for injury/accident		13. Address, City, State & Zip			14. Phone Number ()	
15. Have you been unable to work as a result of this illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		16. What was the <u>last</u> day that you actually worked?		17. What was the <u>first full</u> day that you were unable to work?		
18. Have you resumed work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when: _____			19. Do you expect to resume work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when: _____			
20. What type of work do you normally do? <input type="checkbox"/> Heavy work activity. No limitations of functional capacity. <input type="checkbox"/> 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. <input type="checkbox"/> Light work activity. Exerting up to 20 pounds of force occasionally and/or up to 10 pounds of force frequently. <input type="checkbox"/> 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.						
21. Treating Physician(s). List any doctors currently treating your disability first, then any others coordinating your care.						
Physician's Name: _____		Specialty _____		Phone _____		
Physician's Name: _____		Specialty _____		Phone _____		
Physician's Name: _____		Specialty _____		Phone _____		
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.						

The information provided by me on this form is 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. (Claim not valid unless signed by Participant.)

Participant's or Authorized Representative's Signature

X Date:

Part 4 – Authorization for Release of Information

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.

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 if eligible, 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 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.

I understand that:

- This authorization is voluntary and I may refuse to sign it.
- 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.
- 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.
- The information used or disclosed pursuant to this authorization may be redisclosed by the receiving person or organization and, upon redisclosure, may no longer be protected by federal privacy laws.
- 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.
- 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.
- Weekly Disability benefits cannot be paid unless **all sections** of this form are completed by me, my medical doctor as indicated, and, then only to the extent I am eligible to receive a benefit.

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. (Claim not valid unless signed by Participant.)

Participant's or Authorized Representative's Signature X Date:

Printed Name of Representative* (if applicable): Relationship to Participant:

*If a representative is completing this form for you, include documentation that grants authority to act as the Participant's Representative

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 5 – To be Completed in its entirety by the Attending Physician’s Office		
1. Patient’s Name(Last), (First) (MI)	2. Patient’s BCBS I.D. Number CGO	3. Patient’s Date of Birth
4. Nature of sickness or injury (describe complications, if any) _____ _____		
Primary Diagnosis	ICD10: _____	
Secondary Diagnosis	ICD10: _____	
Other dx or complication	ICD10: _____	
5. For medical reasons, the patient cannot perform his/her job duties and will need to be absent from work as a result of this disability:		
Start date	End date	
6. Frequency of Medical Appointments: _____ Next Appointment Date: _____		
7. Do you anticipate a return to work <u>without</u> restrictions? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when? _____		
8. Procedures. Surgery date (if applicable) _____		
a. Primary Procedure _____	Primary CPT Code _____	
b. Secondary Procedure _____	Secondary CPT Code _____	
c. Other Procedures _____	Other CPT Codes _____	
9. Medication(s)/Dose/Frequency _____ _____		
Impairment from medication effects _____		
10. Symptoms and severity: _____ _____		
11. Date symptoms first began or accident occurred: : _____		
12. Has patient ever had the same or a similar condition? <input type="checkbox"/> No. <input type="checkbox"/> Yes, state when and describe: _____ _____		
13. Is the claim a result of job activity? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
14. Treatment summary: _____ _____		

15. 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.

16. Objective Findings that substantiate impairment (labs, physical/mental status examination, other testing): _____

17. Subjective findings that substantiate impairment: _____

18. Referring Physicians

Name	Specialty	Phone
Name	Specialty	Phone
Name	Specialty	Phone

19. Attending Physician

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