| Fox Valley & Vicinity Construction Workers<br>Welfare Fund Disability Claim Form<br>Please return this form to:   | Time Loss Benefits  |
|---|---|
|   | Weekly Benefit: \$450 less FICA/MEDC  |
| Group Administrators, Ltd.<br>953 American Lane, Suite 100  | Max Benefit Period: 26 Weeks  |
| Schaumburg, IL 60173<br>Fax # 847-519-1979  | Waiting Period: Accident 1 <sup>st</sup> day<br>Illness 8 <sup>th</sup> day |
| For Office Use Only   | igible  |
| A. TO BE COMPLETED BY MEMBER (please print)   |   |
| Last Name First Nam   | ne MI   |
| Address   |   |
| City State  | Zip Phone #   |
| Local Union# SSN #  | DOB Date Employed   |
| First full day unable to work   | Date returned to work   |
| Description of Injury or Illness:   |   |
|   |   |
|   |   |
|   |   |
| Is disability due to an accident? Yes No  | Date of accident Time   |
|   |   |
| Where did accident occur?   |   |
|   |   |
| Describe accident:  |   |
|   |   |
| Is this disability due to occupational cause? Yes   | No If yes, complete section B   |
| Have you filed, or do you intend to file for Worker's C   |   |
| I hereby authorize any physician, hospital, or medically realted facility, insurance company or other organization, institution or person to release to the Fox Valley & Vicinity Construction Workers Welfare Fund and/or Group Administrators any records or information relating to my claim or any facts concerning my injury illness or treatment. |   |
|   |   |
| Member Signature  | Date  |
| B. TO BE COMPLETED BY EMPLOYER ONLY   |   |
| Employer Name   | Phone #   |
| Address   |   |
| City State  | Zip   |
|   | ability due to occupational cause? Yes D No D                               |
| Date (first full day) employee was unable to work:  |   |
| Date Resumed work Expected to Resume work Terminated  |   |
|   |   |
| Employer Signature Title  | Date  |

| Attending Physician's Statement must be complted and returned to the address above.   |  |
|---|--|
| If you have questions regarding your Time Loss, Please call GAL at 847-519-1880 or 800-323-1683.  |  |
| C. ATTENDING PHYSICIAN'S STATEMENT  |  |
|   |  |
| 1. Name of Patient DOB SSN #  |  |
| 2. Diagnosis – Please include the primary diagnosis and list any secondary conditions.  |  |
|   |  |
| Date of Examination   |  |
| Diagnosis (including any complications) include ICD10 and/or DSM IV Multi Evaluation Nomenclature and Code                                  |  |
| Number  |  |
| Objective Findings (including current x-rays, EKGs, psychiatric testing, lab data and clinical findings)                                    |  |
|   |  |
| Symptoms  |  |
| Is this condition due to: Accident  |  |
| Date symptoms first appeared or accident occurred:  |  |
| Is the accident or sickness related to patient's employment? Yes No Unknown   |  |
| Date restrictions and limiations began:   |  |
| Has patient ever been treated for the same or similar condition? Yes D No D If yes, state when and describe.                                |  |
| 3. Information about the patient's ability to work – Information is critical to understanding your patient's condition.                     |  |
| Has patient been released to work in his/her occupation? Yes No In any occupation? Yes No I   |  |
| If patient has demonstrated a loss of function, please provide restrictions and limitations and the date they began in                      |  |
| the space provided below.   |  |
|   |  |
|   |  |
|   |  |
| Fully describe restrictions and limitation.   |  |
| Restrictions (What the patient should not do)   |  |
| Limiations (What patient cannot do)   |  |
| Patient continuously totally disabled dates (Claim can not be processed without this information) Disability Date From: Disability Date To: |  |
| Disability Date From:       Disability Date To:         If pregnant, expected date:       If delivered, actual delivery date:               |  |
| Delivery type: Normal C-Section   |  |
| Date of first visit for this illness or injury: Date of next visit:   |  |
| Date of last visit: Frequency of visits:  |  |
| Is patient: Ambulatory Bed Confined House Confined Hospital Confined  |  |
| Has patient been admitted to the hospital?  |  |
| Have you completed claim forms regarding this patient for other insurance carriers? Yes D No D If yes, state the                            |  |
| date and name of insurance company:   |  |
| 4. Names and addresses of treating physicians   |  |
|   |  |
| Print or Type Name Degree Medical Specialty Phone #   |  |
|   |  |
|   |  |
| Address   |  |
|   |  |
| City, State, Zip  |  |
|   |  |
| Signature pf Physician Date   |  |
|   |  |