

Fox Valley & Vicinity Construction Workers Welfare Fund Disability Claim Form Please return this form to: Group Administrators, Ltd. 953 American Lane, Suite 100 Schaumburg, IL 60173 Fax # 847-519-1979	<p align="center"><u>Time Loss Benefits</u></p> Weekly Benefit: \$450 less FICA/MEDC Max Benefit Period: 26 Weeks Waiting Period: Accident 1 st day Illness 8 th day		
For Office Use Only <input type="checkbox"/> Eligible <input type="checkbox"/> Not Eligible			
A. TO BE COMPLETED BY MEMBER (please print)			
Last Name	First Name	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 <input type="checkbox"/> No <input type="checkbox"/> If yes, complete section B			
Have you filed, or do you intend to file for Worker's Compensation? Yes <input type="checkbox"/> No <input type="checkbox"/>			
I hereby authorize any physician, hospital, or medically related 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 IF OCCUPATIONAL			
Employer Name		Phone #	
Address			
City	State	Zip	
Employee Name		Is disability due to occupational cause? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Date (first full day) employee was unable to work:			
Date	<input type="checkbox"/> Resumed work	<input type="checkbox"/> Expected to Resume work	<input type="checkbox"/> Terminated
Employer Signature		Date	

