A7T9

Central Midwest Regional Council of Carpenters' Welfare Fund Weekly Accident and Sickness Application

APPLICATION MUST BE COMPLETED BY EMPLOYEE, EMPLOYER, AND PHYSICIAN AND RETURNED TO THE FUND WITHIN 90 DAYS OF THE DATE THE PHYSICIAN CERTIFIES THE DISABILITY AND NO LATER THAN 180 DAYS AFTER THE FIRST DAY OF DISABILITY. A COMPLETED APPLICATION INCLUDES PROVIDING OR EXECUTING DOCUMENTS RELATED TO POSSIBLE THIRD PARTY LIABILITY REQUESTED BY THE FUND OFFICE.

Return completed documents to:

Central Midwest Regional Council of Carpenters' Welfare Fund
P. O. Box 1257
Troy, MI 48099

Phone: (800) 700-6756
Email to: stdisability@benesys.com
Fax to: (248) 556-2596

Part 1 – To be completed by the **EMPLOYEE** (**Each question must be fully answered**)

1. Name: _____ Birth Date: _____ SSN/Alt ID: _____

   Street: _____ City and State: _____ Zip: _____

   Phone: _____

2. Last date of work before disability: _____ 3. Date disability started: _____

4. Did your disability happen at work? Yes _____ No _____ 5. Is your disability the result of: Accident _____ Illness _____

6. Please explain your Disability. If the result of an accident, advise, how, when and where it occurred: _____

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7. Have you, or do you intend to file this claim under Workmen's Compensation? Yes _____ No _____

8. Have you received Unemployment Compensation Benefits since your last day of work? Yes _____ No _____

   If YES, what dates have/will you receive compensation? _____

9. Authorization for Physicians, Hospitals and Other Institutions: I hereby authorize you by this form (or by copy) to provide the Central Midwest Regional Council of Carpenters' Welfare Fund with any information you have regarding my medical history and physical condition. I certify the above answers are true and complete to the best of my knowledge and belief.

Participant Signature (do not print): _____ **Date**: _____

Part 2 – To be completed by the EMPLOYER:

Occupation: _____ Last Date Worked: _____

Date Returned to Work: _____ Did disability occur due to Occupational Causes? _____

Has Employment Terminated? _____ When? _____ Reason? _____

Does the Employee have other insurance coverage for this claim? _____

If Yes, explain: _____

Employer: _____ Signed by: _____

Date: _____ Title: _____

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Part A - To be completed by EMPLOYEE:

Name: _____ Birth Date: _____ SSN/Alt ID: _____

Street: _____ City and State: _____ Zip: _____

Phone: _____

Part B – ATTENDING PHYSICIAN'S STATEMENT

1. Nature of disability/ICD-10 (Describe complications if any): _____
2. Was this sickness or injury caused by the patient's employment? Yes _____ No _____
3. Nature of surgical procedure, if any/CPT: _____
4. Date surgery performed: _____
5. Dates of Treatment, indicate first and any following Consultations: _____
6. The patient has been continuously disabled (unable to work): **From:** _____ **Through** _____
   (if unsure provide tentative date)
7. If still disabled, when should patient be able to return to work? _____

Physician's Signature: _____ **Date:** _____

Physician's Name (please print): _____ License: _____

Address: _____ Physician's Phone Number: (____) _____

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DIRECT DEPOSIT – Optional

1. Employee's Name: _____ Employee's SSN: _____
2. Bank Name: _____ City / State /Zip _____
3. Routing / Transit No.: _____ Account No.: _____
4. Is this a: CHECKING account ☐ SAVINGS account: ☐

Signed: _____ Date: _____

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