IRON WORKERS' HEALTH FUND OF EASTERN MICHIGAN
P.O. BOX 99219
TROY, MICHIGAN 48099
(248) 347-3100 Or Toll Free (800) 572-8553
Email: STDisability@benesys.com; Fax: (248)556-2596

Loss of Time (Weekly Disability) Claim Form

NOTE: YOU MUST ANSWER ALL QUESTIONS COMPLETELY OR YOUR APPLICATION FOR BENEFITS WILL BE DENIED

TO BE COMPLETED BY THE MEMBER:

MEMBER'S NAME (PLEASE PRINT)

ADDRESS

CITY STATE ZIP

DATE OF BIRTH SOCIAL SECURITY #

PHONE

NAME OF LAST EMPLOYER LAST DAY WORKED

COMPLETE ONLY IF CLAIM CAUSED BY INJURY	DATE OF INJURY, HOUR (AM/PM) WHERE DID ACCIDENT HAPPEN
	HOW DID ACCIDENT HAPPEN?
COMPLETE ONLY IF CLAIM CAUSED BY ILLNESS	HAS THIS CONDITION BEEN TREATED BEFORE? ☐YES ☐NO
	WHEN WAS THE PHYSICIAN FIRST CONSULTED? DATE:
COMPLETE ONLY IF HOSPITALIZED	ADMISSION DATE:
	WAS SURGERY PERFORMED: ☐YES ☐NO
IS DISABILITY A RESULT OF EMPLOYMENT	☐YES ☐NO

I CERTIFY THAT THE ABOVE INFORAMTION IS TRUE AND CORRECT. I HERBY AUTHORIZE ALL DOCTORS, HOSPITALS OR OTHER INSTITUTIONS RENDERING CARE AND TREATMENT TO FURNISH THE IRON WORKERS' HEALTH FUND OF EASTERN MICHIGAN WITH FULL INFORMATION REGARDING TREATMENT RENDERED, INCLUDING COPIES OF THEIR RECORDS. I ALSO AUTHORIZE ANY UNION TRUST FUND, EMPLOYER OR INSURANCE CARRIER TO FURNISH THE IRON WORKERS' HEALTH FUND OF EASTERN MICHIGAN WITH INFORMATION REGARDING BENEFITS TO WHICH I OR ANY OF MY DEPENDENTS MAY BE ENTITLED TO.

DATE MEMBER'S SIGNATURE

ATTENDING PHYSICIAN'S STATEMENT ON REVERSE SIDE

PART A: **TO BE COMPLETED BY PATIENT (MEMBER)**

PATIENT'S NAME		DATE OF BIRTH	SOCIAL SECURITY NO
PATIENT'S ADDRESS	CITY	STATE ZIP	PHONE

CLAIMANT'S ASSIGNMENT (READ BEFORE SIGNING):

I, member stated above, a participant in the Iron Workers' Health Fund of Eastern Michigan (the "Plan"), authorize the plan, its Trustees and service providers (i.e. business associates) to use and disclose my protected health information (except for psychotherapy ntes) for the purpose of processing and administering my claim for Loss-of-Time benefits. I understand this authorization will expire when i am no longer eligible for such benefits. i understand that I have the right to revoke it at any time, except to the extent that it has already been relied upon. I understand that if i decide to revoke this authorization, i must give notice of my decision in writing and send it to the IW Health Fund, P.O. Box 99219, Troy, MI 48099. I understand that health information disclosed pursuant to this authorization may be redisclosed by the persons authorized below, and that the Plan cannot prevent or protect such redisclosures.

SIGNATURE OF CLAIMANT _____ DATE _____

PART B **ATTENDING PHYSICIAN'S STATEMENT**

1. DIAGNOSIS AND CURRENT CONDITIONS (IF DIAGNOSIS CODE OTHER THAN ICDA* USED, GIVE NAME)

2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? ☐ YES ☐ NO

PREGNANCY? ☐ YES ☐ NO IF YES, APPROXIMATE DATE PREGNANCY COMMENCED: _____

3. REPORT OF SERVICES (OR ATTACH ITEMIZED BILL) (IF PREVIOUS FORM SUBMITTED, ONLY SHOW DATES AND SERVICES SINCE LAST REPORT)

DATE OF SERVICES	PLACE OF SERVICES†	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE-IF USED (IF CODE OTHER THAN CPT** USED, GIVE NAME)

IO - DOCTOR'S OFFICE IH - INPATIENT HOSPITAL NH - NURSING HOME

H - PATIENT'S HOME OH - OUTPATIENT HOSPITAL OL - OTHER LOCATION

*ICDA INTERNATIONAL CLASSIFICATION OF DISEASES

** CPT- CURRENT PROCEDURAL TERMINOLOGY (CURRENT EDITION)

4. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED	5. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION
6. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? ☐ YES ☐ NO IF YES, WHEN AND DESCRIBE:	7. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO
8. PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK): FROM THRU	9. PATIENT WAS PARTIALLY DISABLED FROM THRU
10. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK	11. PATIENT WAS HOUSE CONFINED FROM THRU

12. DOES PATIENT HAVE OTHER HEALTH COVERAGE?
☐ YES ☐ NO IF YES, PLEASE IDENTIFY

MUST BE FURNISHED UNDER AUTHORITY OF LAW, INDIVIDUAL PRACTITIONERS -SS NO. ALL OTHERS -I.D. NO.

13. I DO NOT ACCEPT ASSIGNMENT ☐

DATE PHYSICIAN'S NAME (PRINT) SIGNATURE DEGREE

ADDRESS CITY ST ZIP TELEPHONE

Note: Light- duty work is NOT an option in Ironwork

APPROVED BY COUNCIL ON MEDICAL SERVICE. AMA 10-62