I.U.P.A.T. Welfare Fund

Return completed form to:
I.U.P.A.T. Welfare Fund
P.O. BOX 99459
Troy, MI 48099-9998

Phone #: (330) 779-8865
Fax #: (248) 556-2596
Email: stdisability@benesys.com

Dear Participant:

You have recently requested Sick and Disability Benefits. In order to receive such benefits, you must complete the following forms and return them to the I.U.P.A.T. Welfare Fund Office:

- **Disability Claim Report** – This form must be completed by you (*Part I*) and your physician (*Part II*).
- **Subrogation/Reimbursement Acknowledgment** – Your spouse, a relative, or a friend may witness your signature. This does not need to be notarized.
- **Accident Claim Information Form** – This form is not only necessary for your disability benefits, but it will also be used as confirmation of your accident for the processing of any medical claims we receive in relationship to the injury/injuries.
- **Workers' Compensation Questionnaire** – This form is not only necessary for your disability benefits, but it will also be used as documentation of your workers' compensation status for the processing of any medical claims we may receive in relationship to injury/injuries. This form must be notarized if applicable**. In addition, if you have been denied Workers' Compensation, a copy of the denial must be attached.**

All four of the above forms must be filled out and returned to the Fund Office whether or not they apply to your specific situation.

If you accept any disability checks after you have returned to work or have settled a Workers' Compensation claim for your illness or injury, it will be your responsibility to reimburse I.U.P.A.T. Welfare Fund for any monies paid to your or on your behalf by the Fund for such illness or injury.

IF YOUR PHYSICIAN RELEASES YOU FOR FULL-DUTY WORK, YOU MUST IMMEDIATELY NOTIFY THE FUND OFFICE.

If you should have any questions, please contact the Fund Office at the number above.

Sincerely,

I.U.P.A.T. Welfare Fund

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Disability Claim Form

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

1. Name _____ 2. Birth date: _____SSN: _____
   Street _____ 3. Last date of work before disability _____
   City and State_____ Zip code_____ Member's Phone#_____
4. My disability is_____ Injury? _____
   Illness? _____
5. It happened: Date_____ At Work? _____
   Time_____ At Home? _____
6. How did it happen? _____
7. Occupation _____
8. Your present or last Employer's Name and Address _____
9. Have you, or do you intend to file this claim under Workmen's Compensation? Yes_____ No_____
10. Have you received Unemployment Compensation Benefits since your last day of work? Yes _____ No _____
11. Date Resumed Work _____

To Physicians, Hospitals and Other Institutions: I hereby authorize you by this form (or by photographic copy hereof) to give I.U.P.A.T. Welfare Fund 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.

Dated_____ Mr._____ Mrs._____ Miss_____ _____
SIGNATURE – Please Do Not Print

Part II – ATTENDING PHYSICIAN'S STATEMENT

1. Nature of sickness or injury/ICD10 (Describe complications if any) _____
   _____
2. Was this sickness or injury caused by patient's employment? Yes_____ No_____
   Illness? _____ Injury? _____
   Was it aggravated by Patient's employment? If "Yes" explain_____
3. Nature of surgical procedure, if any/CPT (Describe fully) _____
   _____
4. Date surgery performed: _____
5. Give dates of treatments:

	FIRST CONSULATION	OTHER CONSULTATIONS DURING THIS PERIOD OF DISABILITY
Office	_____	_____
Hospital	_____	_____

6. The patient has been continuously disabled (unable to work): From_____
   Through (if unsure give tentative date) _____
   If still disabled, when should patient be able to return to work? _____
7. Remarks_____
   Date _____ Physician's Name (Print) _____Degree_____
Physician's Signature_____ Address_____

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Reimbursement Agreement

This letter is to advise you that the Plan will pursue its reimbursement and subrogation rights when benefits are paid due to accidental injury for which another party may be liable. The Plan is not interested in depriving you of any rights you may have against a third party and is prepared to cooperate with you and any attorney you may retain in enforcing your claim. Please sign the below Agreement acknowledging that you agree to cooperate with the Plan in providing the information necessary to protect the Plan's right and agree to reimburse the Plan if you have a successful third party action.

I _____, residing at _____

_____

and covered under the Plan for medical benefits incurred as a result of injuries suffered on _____ (date) by me or my dependent _____.

In accordance with the subrogation and reimbursement provision of the Plan, the undersigned herby agrees to reimburse and pay promptly to the Plan an amount not exceeding the aggregate amount of benefits paid or to be paid to me or on my behalf under said Plan for charges incurred as a result of injury or disease out of any recovery by settlement, judgment or otherwise from such person or organization or such person's organization's insurance carrier. The undersigned further agrees to execute instruments and papers, furnish information and assistance and other necessary and related action as the Fund may require, due to the unforeseen circumstances, facilitate its rights of subrogation and reimbursement under the Plan.

I further understand that failure to permit subrogation or to reimburse the Plan in accordance with the terms of this Plan and this letter may result in the Fund setting off the amounts owed pursuant to its subrogation right or right of reimbursement against future claims made by me or my dependents.

Signature of Insured _____

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◆»Phone (330) 779-8865 ◆» Facsimile (248) 556-2596
◆»Email: stdisability@benesys.com

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Accident Claim Information Form

Insured Participant: _____
Social Security Number: _____
Date of Accident: _____
Place Accident Occurred: _____

Please check what type of accident/incident this information is for:
Automobile _____ Workers' Compensation _____ Other _____

Detailed Description of Accident: _____

_____

_____

Is another party responsible for the injury or illness? Yes _____ No _____
If yes, please give the name and address of the party:
Name: _____

Address: _____

Is Participant covered by another insurance policy? Yes _____ No _____
If yes, please provide the following information:
Insurance Company Name: _____
Insurance Company Address: _____
Insurance Company Telephone Number: _____
Adjuster's Name: _____
Policy Number: _____ Claim Number: _____

Has the Participant received any money or has any money been paid on the Participant's behalf?
Yes _____ No _____
If yes, indicate the dollar amount, source and date:
_____

Has the participant retained a lawyer? Yes _____ No _____
If yes, please provide the following information:
Name of Attorney: _____
Address: _____
Phone: _____

I have read and understand the Subrogation/Reimbursement Rights of I.U.P.A.T. Welfare Fund of Western Pennsylvania. I understand that if I receive or will receive any recovery amount from a third party or a third party's insurer for any injury or illness, I must reimburse the Plan for any monies which the Plan has paid to me or on my behalf as a result of any such injury or illness.

Date: _____ Signature of Participant: _____

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Workers' Compensation Questionnaire

Insured Participant: _____

Social Security Number: _____

Date of Accident: _____

Has the Participant applied for Workers' Compensation for his/her injury? Yes _____ No _____

Is the Participant receiving Workers' Compensation for his/her injury? Yes _____ No _____

If yes, please provide the following information:

Name of Company: _____

Address: _____

Insurance Company Telephone Number: _____

Adjuster's Name: _____

Claim Number: _____

Amount: _____

Has the Participant retained a lawyer? Yes _____ No _____

If yes, please provide the following information:

Name of attorney: _____

Address: _____

Phone: _____

I understand that the Plan does not pay benefits for an injury or illness for which benefits are payable under any Workers' Compensation law, occupational disease law or similar legislation. I understand that the I.U.P.A.T. Welfare Fund of Western Pennsylvania must be reimbursed for any monies which the Fund has paid to me or on my behalf for which benefits are payable or will be paid under any Workers' Compensation law, occupational disease law or similar legislation.

Date: _____ Signature of Participant: _____

SIGNATURE MUST BE NOTARIZED
(A notary is available at the Fund Office)

Signed & Subscribed before me on this _____ day of _____ 20 _____ .

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