AUTOMOBILE MECHANICS' LOCAL 701 WELFARE FUND

361 S. FRONTAGE ROAD, SUITE 100 | BURR RIDGE, IL 60527

TELEPHONE: (708) 482-0110 | TOLL FREE: (800) 704-6270 | FAX: (708) 482-9140

email:701claim@mech701-benefits.org

web:www.mech701-benefits.org

☐ **PLEASE CHECK IF YOUR ADDRESS HAS CHANGED SINCE YOUR LAST CLAIM**

CLAIM FOR SHORT-TERM DISABILITY BENEFITS

PART I MEMBER'S STATEMENT (PLEASE PRINT)

Member's Name	Home Telephone Number ( ) Cell Phone Number ( )	Date of Birth / / _____Male _____Female	ID#/SS#

Home Address (Street, City, State, Zip)

Current job title with your employer

Briefly describe the daily duties of your job

Date first treated for current condition / /	Name of Physician or Facility

Is this Disability due to: _____ Motor Vehicle Accident _____ Other Accident _____ Sickness
_____ Work-related Injury/Sickness _____ Pregnancy

Please describe your medical condition(s) or injury that is resulting in your disability. When did the symptoms first appear?
If related to an injury, state **WHEN**, **WHERE** and **HOW** the injury occurred.

Are you pursuing reimbursement from **ANY** other party or insurance carrier in relation to this condition? _____Yes _____No
If yes, please provide the name, address and telephone number of the other party or insurance carrier.

Have/will you receive any salary/vacation/sick pay for this period of disability: _____Yes _____No

If yes, provide specific dates paid by your employer _____/_____/_____ through _____/_____/_____

IF YOUR CLAIM WAS DENIED BY THE WORKERS' COMPENSATION CARRIER FORWARD A COPY OF THE DENIAL LETTER WITH YOUR CLAIM

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct and complete. I will reimburse the fund for any over-payment made to me or in my behalf due to error or omission on this form.

_____ _____
SIGNATURE OF MEMBER OR LEGAL REPRESENTATIVE DATE

_____ _____
PRINTED NAME OF LEGAL PERSONAL REPRESENTATIVE RELATIONSHIP TO MEMBER

WHEN RELEASED TO RETURN TO WORK FAX A COPY OF THE PHYSICIAN'S RELEASE TO 708-482-9140

THE PATIENT MUST PAY ANY COST FOR COMPLETION OF THIS FORM

PART II ATTENDING PHYSICIAN'S STATEMENT (ALL QUESTIONS MUST BE ANSWERED TO AVOID DELAY)

HISTORY

Name of Patient (Last, First, M.I.)- Please Print | Date of Birth / /

Patient's symptoms result from (check all that apply):

_____Employment _____Illness _____Auto Accident _____Other Accident _____Pregnancy Type of delivery _____

Date Symptoms first appeared _____ /_____/_____ Expected/Actual Date of Delivery _____

Name and address(es) of other treating physician(s): _____

Hospital name: Confinement dates: / / through / /

DIAGNOSIS

Diagnoses with ICD9-CM codes: list in decending order of severity (including any complications). Please go to the appropriate assessment section and elaborate.

ICD-9 _____ _____ _____ _____

Subjective symptoms:

Objective findings:

TREATMENT

Date of first visit: / / Date of last visit: / / Frequency: _____Weekly _____Monthly _____Other

Nature of treatment (including surgery, medications, therapies prescribed, if any):

Specific restrictions and limitations:

IMPAIRMENTS

Physical Impairments (as defined in Federal Dictionary of Occupational Titles)

_____Class 1 No limitation of functional capacity; capable of heavy work*. No restrictions. (0-10%)
_____Class 2 Medium manual activity*. (15-30%)
_____Class 3 Slight limitation of functional capacity; capable of light work*. (35-55%)
_____Class 4 Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60-70%)
_____Class 5 Severe limitation of functional capacity; incapable of minimum (sedentary*) activity. (75-100%)

Remarks:

Mental Impairments (If Applicable)

a. Please define "stress" as it applies to this patient

b. What stress and problems in interpersonal relations has patient had on the job?

_____Class 1 Patient is able to function under stress and engage in interpersonal relations (no limitations)
_____Class 2 Patient is able to function under stress and engage in interpersonal relations (slight limitations)
_____Class 3 Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
_____Class 4 Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
_____Class 5 Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Remarks:

PROGNOSIS

Is patient now totally disabled? Patient's Job _____Yes _____ No

Any Other Work _____Yes _____No

Date patient became disabled due to present illness / /

When do you expect a fundamental or marked change in the future?

_____ 1 Month _____ 1-3 Months _____3-6 Months _____Never

If not disabled was patient released to return to work?

_____Yes _____No _____ Full Duty _____ Restricted Duty

Patient was continuously disabled (unable to work):

From / / To / /

If still disabled, date patient should be able to return to work / /

Date of next scheduled appointment: / /

Reason unable to work, in detail:

The above statements are true and complete to the best of my knowledge and belief

Physician Name (Please Print)	Degree/Speciality	Telephone ( )
Address (Street, City, State, Zip)		
Signature	Tax Identification #	Date

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CLAIM FOR SHORT-TERM DISABILITY BENEFITS

PART III EMPLOYER'S STATEMENT (ALL QUESTIONS MUST BE ANSWERED TO AVOID DELAY)

Employer Name	Employer Phone Number ( )
Employer Address (Street, City, State, Zip)	
Employee Name	Employee Social Security Number _____-_____-_____ Employee Date of Birth / /
Actual last day worked _____/_____/_____ _____Hours worked	Mon Tues Wed Thurs Fri Sat Sun Normal Work Schedule ____ ____ ____ ____ ____ ____ ____ _____Hours/Day _____Hours/Week
Date Employee Terminated _____/_____/_____	Reason for leaving work _____Disability _____Resigned _____Terminated _____Layoff _____Retired _____Leave of Absence
Can the employee's job be modified to allow for return to work? _____Yes _____No _____Maybe, depending on restrictions	Date employee returned to work _____/_____/_____ _____Full Time _____With Restrictions
Did this Disability arise out of employment? _____Yes _____No If yes, please explain Has a Workers' Compensation Claim been filed? _____Yes _____No	
Is this employee eligible for salary continuation/sick leave/vacation pay? _____Yes _____No Date payments begin / / Date payments end / /	
Employee's Job Title	
Brief description of major job duties	

Please contact the employee's direct supervisor and then CIRCLE the strength demand which best describes the employee's job:

S - Sedentary	10 Lbs Maximum lifting, occasional lift/carry of small articles. Some occasional walking or standing required
L - Light	20 Lbs Maximum lifting with frequent lift/carry up to 10 Lbs. A job is light if less lifting is involved but significant walking/standing is done or if done mostly sitting but requires push/pull on arm or leg controls.
M - Medium	50 Lbs Maximum lifting with frequent lift/carry up to 25 Lbs.
H - Heavy	100 Lbs Maximum lifting with frequent lift/carry up to 50 Lbs.
V - Very Heavy	Over 100 Lbs lifting with frequent lift/carry over 50 Lbs.

The above statements are true and complete to the best of my knowledge and belief

Name of person completing form (please print)		Telephone Number ( )
Title of person completing form	E-mail address	Fax Number ( )
Signature		Date Signed

PLEASE NOTIFY THE FUND OFFICE WHEN THE EMPLOYEE RETURNS TO WORK 708-482-0110

HIPAA AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FOR SHORT-TERM DISABILITY BENEFITS

Member Name _____**ID#**_____**DOB**_____

Persons/Categories of persons providing the information: Any provider of medical services, insurance company, Social Security Administration, governmental agency, vocational provider or employer having medical information with respect to any physical or mental condition of mine.

I hereby authorize the use or disclosure of my protected health information as described below to the **Automobile Mechanics' Local 701 Welfare Fund.**

Information to be disclosed: All information necessary to allow the Automobile Mechanics' Local 701 Welfare Fund or its representatives to determine my eligibility for short-term disability benefits and to process my disability claim. Such information may include, but is not limited to: Any and all medical/dental records relating to my physical and/or mental health whether for treatment or evaluation purposes, pharmacy records and strength/functional testing.

The sole purpose of this disclosure is for the adjudication of my claim for short-term disability benefits.

I understand the following:

- This authorization is voluntary and I may revoke it at any time by contacting the Automobile Mechanics' Local 701 Welfare Fund but any such revocation will not affect any actions that the Automobile Mechanics' Local 701 Welfare Fund took before receipt of the revocation.
- I may refuse to sign this authorization; however, if I refuse to sign this authorization I may not receive short-term disability benefits under the plan.
- I agree that photocopies of this authorization shall be as valid as the original.
- I may inspect and/or copy the health information described above.
- My medical treatment or payment of medical benefits cannot be conditioned upon whether I sign this authorization.
- If there is a conflict between a prior request for restrictions and this authorization, this authorization controls.
- This authorization is effective from the date signed below until my disability claim ends or 12 months from the date signed below, whichever is earlier.

SIGNATURE OF MEMBER OR LEGAL PERSONAL REPRESENTATIVE DATE

PRINTED NAME OF LEGAL PERSONAL REPRESENTATIVE RELATIONSHIP TO MEMBER

HIPAA AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO THE AUTOMOBILE MECHANICS' LOCAL 701 PENSION FUND

In addition to the above authorization, I further authorize the Automobile Mechanics' Local 701 Welfare Fund to release information regarding the duration of this period of short-term disability to the Automobile Mechanics' Local 701 Pension Fund. This authorization is effective for 12 months from the date signed below.

SIGNATURE OF MEMBER OR LEGAL PERSONAL REPRESENTATIVE DATE

PRINTED NAME OF LEGAL PERSONAL REPRESENTATIVE RELATIONSHIP TO MEMBER