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
website: 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)		Email Address: ______________________	
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/Injury _______ Sickness/Illness
______ 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 accident/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 & COMMISSION FORWARD A COPY OF THE DENIAL LETTER(S) 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, PLEASE 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 ICD10-CM codes: list in decending order of severity (including any complications). Please go to the appropriate assessment section and elaborate. ICD-10 ________________ ________________ ________________ ________________

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/Specialty (*must be signed by Medical Doctor - MD or Doctor of Osteopathic - DO*)	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
If Yes, complete dates below.

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 AT 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