



SHORT TERM DISABILITY INCOME APPLICATION

Please send the original claim to:

IUOE • Local 399 Health & Welfare Fund
c/o Elite Administration
1300 W. Higgins Road • Suite 208 • Park Ridge, IL 60068
For Assistance, Call (312) 372-9870 Ext. #3

Local 399's Health and Welfare Plan provides covered members with a basic level of income if you become disabled and cannot work because of a non-occupational injury or illness. This benefit has a 14-day waiting period and pays \$250 per week for a maximum of 26 weeks based upon the length of your disability. This application has three parts to be completed: member, employer and physician.

STATEMENT OF MEMBER

Full Name: _____ H&W ID (or SS#) _____
Last First Middle

Street Address: _____ Date of Birth: _____ / _____ / _____
Month Day Year

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Describe the onset and nature of sickness or how and where an accident occurred:

Date of First Symptoms or Accident: _____ / _____ / _____ Date of First Treatment: _____ / _____ / _____
Month Day Year Month Day Year

Date of Surgery (if applicable): _____ / _____ / _____ Date(s) of Hospitalization: _____ / _____ / _____
Month Day Year Month Day Year

First Full Date of Disability (unable to work): _____ / _____ / _____ Date Returned to Work: _____ / _____ / _____
Month Day Year Month Day Year

In signing below, I represent that the statements are true, complete and correctly recorded. I authorize any physician, hospital, or other medical professional who has examined me or has records relating to this disability to furnish medical records or requested information to the Fund's Claims Administrator, Elite Administration.

Signature _____ Date _____

All portions of this claim form must be completed to avoid unnecessary delay in the processing of your request for benefits. If you have any questions when completing this application, please call the Fund Office or Elite Administration at (312) 243-1265. Mail the fully completed form to the Fund's Claims Administrator: Elite Administration, 1300 W. Higgins Road • Suite 208 • Park Ridge, IL 60068 or fax both sides to Elite at (312) 243-8678.

STATEMENT OF EMPLOYER

Employee Name: _____ Social Security Number: _____ / _____ / _____

Date of Hire: _____ / _____ / _____ Date Last Worked: _____ / _____ / _____
Month Day Year Month Day Year

Date(s) Employee Unable to Work Due to Disability: _____

Date Returned to Work: _____ / _____ / _____ Occupational Injury? Yes _____ No _____

Employer Name: _____ Job Site: _____

Signature: _____ Title: _____ Date: _____ / _____ / _____
Month Day Year

Name: _____ Telephone: (_____) _____ - _____ Fax: (_____) _____ - _____

STATEMENT OF PHYSICIAN

Patient's Name: _____ Date of Birth: _____ / _____ / _____
Month Day Year

Diagnosis and Current Conditions: _____

Did disability arise from patient's employment: Yes _____ No _____

Non-occupational accident: Yes _____ (if yes, please specify accident date: _____ / _____ / _____) No _____
Month Day Year

Date symptoms first occurred: _____ / _____ / _____ Date patient first consulted you: _____ / _____ / _____
Month Day Year Month Day Year

Date patient became unable to work with this disability: _____ / _____ / _____
Month Day Year

Date(s) of surgical procedure, if any : _____ / _____ / _____
Month Day Year

If pregnancy, estimated date of delivery: _____ / _____ / _____
Month Day Year

Date returned to work: _____ / _____ / _____ Or, date patient expected to return to work: _____ / _____ / _____
Month Day Year Month Day Year

Describe any circumstances causing disability to be prolonged: _____

Physician Signature: _____ Date: _____ / _____ / _____
Month Day Year

Physician Name (please print): _____ Physician Specialty: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Telephone: (_____) _____ - _____ Fax: (_____) _____ - _____