Health Welfare Fund

H&W LOCAL 399

SHORT TERM DISABILITY INCOME APPLICATION

Please send the completed claim to:

IUOE Local 399 Health & Welfare Fund
c/o Elite Administration
1300 W. Higgins Road Suite 208 Park Ridge, IL 60068
Or fax both sides to Elite at (312) 243-8678

IMPORTANT NOTE: All portions of this claim form must be completed to avoid unnecessary delay in the processing of your request for benefits.

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_____

Employer & Physician To Complete Reverse Side

STATEMENT OF EMPLOYER

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

Date of Hire: _____/_____/_____ (Month / Day / Year) Date Last Worked: _____/_____/_____ (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*: _____/_____/_____) (Month / Day / Year) No _____

Date symptoms first occurred: _____/_____/_____ (Month / Day / Year) Date patient first consulted you: _____/_____/_____ (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: _____/_____/_____ (Month / Day / Year) Or, date patient expected to return to work: _____/_____/_____ (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: (_____) _____- _____