ACRA Local 725 Health and Welfare Fund

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LOSS OF TIME AND/OR DISABILITY STATEMENT

PART A: TO BE COMPLETED BY THE PARTICIPANT CLAIMING BENEFIT FOR SELF

Marital Status

☐ **Single**
☐ **Married** **Date** _____
☐ **Divorced** **Date** _____
☐ **Widowed** **Date** _____

Full Name _____

Date of Birth _____ Social Security # _____

Address _____

PhoneNumber (____) _____ Email _____

Employer Name _____

Is the claim for a job related injury or illness? ☐ Yes ☐ No Have you filed for Worker's Compensation? ☐ Yes ☐ No

Date Disability Began _____ Date Last Worked_____ Is any part of this disability due to your job ☐ Yes ☐ No

Is the claim a result of an accident? ☐ Yes ☐ No (If yes, answer questions below) Is the accident auto-related? ☐ Yes ☐ No

A. Where did the injury occur? _____ Date & Hour _____
B. What were you doing when the injury occurred? _____
_____
C. Describe the injury; Tell how it happened _____
_____

If accident is auto-related;
Name of Insurance Company _____ Policy # _____
Address of Insurance Company _____ Cert No. _____

The above answers are true and complete according to the best of my knowledge and belief. I authorize any employer, insurance company, dental/medical prepayment plan, employee welfare benefit (including the Trust), service organization, physician, practitioner or other person and hospital, including the Veteran's Administration or other institutions, to release or, obtain any medical/dental benefit information that may be required to establish or support the validity of this claim and further authorize said company, person or organization (including the Trust) in its discretion, to disclose to any person, company or organization so requesting my personal dental/medical or claim information obtained in any case study or claim review. A copy of this authorization shall be as the original. I also acknowledge the subrogation right of the Plan, and additionally agree to repay any sums expended by the Plan for injury or sickness from caused or resulting from intentional acts or negligence of another party or source. Additionally, should I receive any payment pursuant to this statement which I am presently or my become ineligible to receive, I agree to return same, and to the Plan's imposition of a reduction in credit hours that may have been afforded/credited to me as a consequence thereof. "See Summary Plan Description".

Signature _____ Date _____
Participant must sign here

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IT IS UNLAWUFUL TO FILE A FALSE OR FRADULENT CLAIM

Part B

ATTENDING PHYSICIAN'S STATEMENT

THIS FORM MUST BE COMPLETED & SIGNED BY THE ATTENDING PHYSICIAN/PROVIDER ONLY

Patient's Name	Date of Birth

Date Patient Able to Return to Work	Date of Total Disability (Estimate if Not Known) From Through

Name & Address of Facility Where Services Rendered (If other than Home or Office)

Name: _____

Address: _____

_____

Diagnosis or Nature of Illness or Injury Related Diagnosis to Procedure in Column by Reference to Number 1,2,3, ETC OR DX Code

1 _____

2 _____

3 _____

4 _____

I attest the information noted above is accurate and truthful based on information provided to me and upon my review and examination of the information and patient.

Attending Physician/Provider Signature_____ Date _____

Name: _____ Facility: _____

Address: _____

Phone: _____ Fax: _____

***PLEASE USE CURRENT PROCEDURAL TERMINOLOGY CODES FOR SURGERY**

21. (H) INPATIENT HOSPITAL	12. (HJ) PATIENTS HOME	32. (NH) NURSING HOME	0. (OL) • OTHER LOCATIONS
22. (OH) OUTPATIENT HOSPITAL	12. DAY CARE FACILITY (PSY)	31. (IL) SKILLED NURSING FACILITY	81. (IL) INDEPENDENT LABORATORY
11. (O) DOCTORS OFFICE	12. NIGHT CARE FACILITY (PSY)	41. AMBULANCE	B. OTHER MEDICAL/SURGICAL

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Part C	EMPLOYER'S STATEMENT

To Be Completed by Employer only if the Participant's lost time from work and is subject to a Worker's Compensation claim
(Required on Initial Filing Only)

Employee's Name:

Employer Information

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

Injury Information

Is Illness or Injury due to Occupational Causes? ☐ Yes ☐ No Worker's Compensation Claim Filed? ☐ Yes ☐ No

Date of Injury _____ Date Last Worked _____ Date Returned to Work _____

I attest the information noted above is accurate and truthful based on information provided to me and upon my review of the information and/or injury report.

Employer's Signature _____ Date _____

Name _____ Title _____
(Please Print)