MCAF 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

Denied for Worker's Compensation? ☐ Yes ☐ No Date of Denial ___________________ Appeal Submitted? ☐ 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

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

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)