United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund

18861 90TH AVE, SUITE A, MOKENA, IL 60448
800-621-5133 * FAX 847-384-0197 * www.ufcwmidwest.org

Statement of Claim — For Income Protection Benefits

A claim for Income Protection Benefits must be submitted immediately to the Benefits Fund Office. Subsequent reports are required at least every three weeks thereafter during the continuance of the disability. Failure to comply with these requirements will jeopardize your right to receive benefits. The Fund, at its own expense, has the right to have you examined by a doctor of its choice as often as it is necessary to establish total disability. If you do not submit to an examination requested by the Benefits Fund Office, benefits may not be paid.

To be Completed by Disabled Employee-Member

1. YOUR FULL NAME (EMPLOYEE-MEMBER)	UFCW ID# or SOCIAL SECURITY NUMBER	OCCUPATION	DAYTIME AREA CODE/PHONE NUMBER

2. STREET ADDRESS	CITY	STATE	ZIP	CHECK ☑ IF NEW ADDRESS ☐

I authorize any physician, medical examiner or practitioner, coroner, hospital, Veterans Administration Hospital, clinic, other medical or medical-related facility, insurance or reinsuring company, consumer reporting agency, employer, school, or group policyholder having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of the patient for whom claim is made, to give to United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund or its legal representative, any and all such information. A photocopy of this authorization shall be as valid as the original.

Date _____ Signature _____ **Employee-Member** sign here

Attending Physician's Statement of Disability (submit any charges on your standard detailed bill)

3. DIAGNOSIS AND CONCURRENT CONDITIONS (if Diagnosis Code other than ICDA used, please give name)

4. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? ☐ YES ☐ NO	IS CONDITION DUE TO PREGNANCY? ☐ YES ☐ NO	IF "YES," APPROXIMATE DATE PREGNANCY COMMENCED	ESTIMATED DATE OF CONFINEMENT

5. DATES OF SERVICE (If previous form submitted to this office, you need show only dates since last report)

6. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO	PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (unable to work) FROM THRU	IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK

7. DOES PATIENT HAVE OTHER HEALTH COVERAGE? ☐ YES ☐ NO	IF "YES," PLEASE IDENTIFY

8. PHYSICIAN'S NAME (PRINT)	DEGREE	AREA CODE/PHONE NUMBER

9. STREET ADDRESS	CITY	STATE	ZIP

Date _____ Physician's Signature _____

Employer's Statement—Employer must complete if Salary Loss is involved

10. FIRST FULL DAY UNABLE TO WORK	DATE RESUMED WORK	DATE EXPECTED TO RESUME WORK	DATE AND TIME LAST WORKED

11. BASIC GROSS WEEKLY EARNINGS	DATE TERMINATED	REASON FOR TERMINATION

12. IF NOT PREVIOUSLY PROVIDED FOR THIS DISABILITY, INDICATE LAST 4 WEEKLY SALARIES PRIOR TO DATE STOPPED WORKING	WEEK #1	WEEK #2	WEEK #3	WEEK #4

13. PRIOR TO THIS DISABILITY, WAS THE EMPLOYEE ☐ LAID OFF ☐ ON LEAVE ☐ RETIRED ☐ DISCHARGED ☐ QUIT

14. IS THIS DISABILITY THE RESULT OF OCCUPATIONAL DISEASE OR INJURY ARISING IN THE COURSE OF EMPLOYMENT? ☐ YES ☐ NO	WILL A CLAIM BE MADE UNDER WORKER'S COMPENSATION? ☐ YES ☐ NO

15. NUMBER OF FULL & PARTIAL SICK DAYS PAID	SICK DAYS PAID FROM THRU	NUMBER OF SICK HOURS PAID

16. AREA CODE/PHONE NUMBER	VALIDATE WITH STORE STAMP

Date _____ Authorized Signature-Employer _____

e-rev0714/mmd