United Food and Commercial Workers Union and Employers Calumet Region Insurance Fund
2625 Butterfield Rd, Suite 208E, Oak Brook, IL 60523
800-621-5133 * Fax 847-384-0197 * www.ufcwmidwest.org

Statement of Claim - For Hospital, Surgical, Medical and/or Income Protection Benefits

Attach bill(s), complete the first page - complete second page if salary is involved - and return to above address

Employee-Member and Claim Information - Receipt of this claim form does not guarantee payment of benefits

1. YOUR FULL NAME (EMPLOYEE-MEMBER) | MAIDEN NAME | UFCW ID# OR SOCIAL SECURITY NUMBER

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

3. DAYTIME PHONE NUMBER | ☐ MALE ☐ FEMALE | DATE OF BIRTH | ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ MARRIED ☐ SEPARATED | DATE MARRIED

4. NAME AND ADDRESS OF ANY NON-UFCW COMPANY WHERE YOU ARE ALSO EMPLOYED

5. FULL NAME OF PATIENT | RELATIONSHIP TO EMPLOYEE-MEMBER

6. DESCRIPTION OF SICKNESS OR INJURY, INCLUDING FULL DESCRIPTION OF WHERE, AND HOW THE INJURY HAPPENED -FAILURE TO SUPPLY ALL REQUESTED INFORMATION WILL DELAY PROCESSING OF YOUR CLAIM.

7. NAME AND ADDRESS OF PHYSICIAN WHO FIRST TREATED THIS CONDITION | DATE FIRST TREATED

8. DATE AND TIME OF INURY OR BEGINNING OF SICKNESS ☐ A.M. ☐ P.M. | IF YOU STOPPED WORK, GIVE DATE | IF YOU RETURNED TO WORK, GIVE DATE | ☐ CHECK IF SICKNESS OR INJURY IS DUE TO THE PATIENT'S EMPLOYMENT (ON-THE-JOB) | ☐ CHECK IF A WORKER'S COMPENSATION CLAIM HAS OR WILL BE FILED

Spouse Information - Complete for all Claims

9. FULL NAME OF SPOUSE | DATE OF BIRTH | SOCIAL SECURITY NUMBER

10. IF DIFFERENT FROM EMPLOYEE-MEMBER, STREET ADDRESS | CITY | STATE | ZIP | DAYTIME PHONE NUMBER

11. NAME AND ADDRESS OF SPOUSE'S EMPLOYER (OR FORMER EMPLOYER) | PHONE NUMBER

Dependent Child Information - Complete Only if Claim is for a Dependent Child

12. DEPENDENT'S FULL NAME - FIRST AND LAST NAME | RELATIONSHIP | DATE OF BIRTH | SOCIAL SECURITY NUMBER

13. IF DIFFERENT FROM EMPLOYEE-MEMBER, STREET ADDRESS | CITY | STATE | ZIP | DAYTIME PHONE NUMBER

14. EMPLOYER NAME AND ADDRESS | CHECK IF NOT EMPLOYED ☐

Other Insurance Information - Complete for all Claims

15. IS PATIENT COVERED UNDER ANY OTHER GROUP HEALTH INSURANCE OR BENEFIT PLAN, SUCH AS, GROUP BLUE CROSS A SCHOOL PLAN, A GOVERNMENT PLAN, AN AUTO INSURANCE PLAN, ETC.? IF "YES," PLEASE PROVIDE THE INFORMATION REQUESTED BELOW. ☐ YES ☐ NO

16. POLICYHOLDER'S FULL NAME - FIRST AND LAST NAME | RELATIONSHIP TO EMPLOYEE-MEMBER | DAYTIME PHONE NUMBER

17. NAME OF PLAN OR COMPANY | POLICY NUMBER

18. ADDRESS | CITY | STATE | ZIP | PHONE NUMBER

Signatures - Employee-Member and Patient (or Parent, if patient is a minor) must sign or benefits cannot be paid

I certify that the above answers and statements, including any accompanying statements, are true and complete to the best of my knowledge and belief. I authorize any physician, medical examiner or practitioner, coroner, hospital, Veterans Administration Hospital, clinic, other 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 UFCW Calumet Region Insurance Fund or its legal representative, any and all such information. A photocopy of this authorization shall be valid as the original.

Date _____ Signature _____ ☜ Employee-Member sign here

Date _____ Signature _____ ☜ Patient (or Parent) sign here

Assignment of Benefits: Authorization to Pay Benefits to Physician, Hospital or Other Provider-Sign only if benefits to be paid directly to provider

I hereby authorize payment directly to the physician or other provider for any Surgical and/or Medical Benefits otherwise payable to me for services in connection with this claim.

Date _____ Employee-Member Signature _____

(See second page to file for Income Protection Benefits)

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 - Be sure you have signed on the front under "Signatures..."

1. YOUR FULL NAME (EMPLOYEE-MEMBER)	UFCW ID# OR SOCIAL SECURITY NUMBER	OCCUPATION

Attending Physician's Statement for Disability Claim

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

3. 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

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

5. 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

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

7. PHYSICIAN'S NAME (PRINT)	DEGREE	PHONE NUMBER

8. STREET ADDRESS	CITY	STATE	ZIP

Date _____ Physician's Signature _____

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

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

10. BASIC GROSS WEEKLY EARNINGS	DATE TERMINATED	REASON FOR TERMINATION

11. 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

12. PRIOR TO THIS DISABILITY, WAS THE EMPOYEE: ☐ LAID OFF ☐ ON LEAVE ☐ RETIRED ☐ DISCHARGED ☐ QUIT

13. 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

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

15. PHONE NUMBER	VALIDATE WITH STORE STAMP

Date _____ Authorized Signature - Employer _____