

RETURN THIS FORM TO:

UNITED FOOD & COMMERCIAL WORKERS
UNION-EMPLOYER HEALTH & WELFARE FUND
9199 Market Place, Ste. 1 • Broadview Heights, Ohio 44147
Telephone (216) 241-2828 WATS 1-800-241-2828



TO AVOID UNDUE DELAY COMPLETE ALL REQUIRED AREAS
OF INFORMATION. YOUR CLAIM CANNOT BE PROCESSED
UNLESS THIS FORM IS COMPLETED IN FULL.

STATEMENT OF CLAIM
TIME LOSS BENEFITS

RETURN IMMEDIATELY

**Completed Form Can Be emailed to:
hwforms@ufcw880funds.com**

TO BE COMPLETED BY EMPLOYER

**Member / Employer to complete
ALL Required Portions**

name of employee _____

\$ _____ RESUMED WORK

basic weekly earnings _____ EXPECTED TO RESUME

first full day unable to work _____ date _____ TERMINATED

DATE RETURNED TO WORK _____

No. OF HOURS AVG. WEEKLY _____

HOURLY RATE _____

WAS THIS DISABILITY DUE TO OCCUPATIONAL CAUSE OR CAUSES? NO YES

HAS A CLAIM BEEN FILED FOR WORKERS' COMPENSATION? NO YES

name of employer (firm name) _____

employer's address _____ telephone number _____

employer please sign _____ date _____

1. TO BE COMPLETED BY EMPLOYEE

please print member's last name _____ first _____ middle _____

home address _____

city - state - zip code _____

home phone number _____ cell phone number _____

date of birth _____ sex _____

occupation _____ local no. _____ social security number _____

email address _____

YES NO

2. ARE YOU MARRIED?

3. IS ILLNESS OR INJURY DUE TO CLAIMANT'S OCCUPATION?

4. WAS THIS DISABILITY DUE TO AN ACCIDENT OR INJURY?
IF SO, PLEASE COMPLETE 4a.

5. IF AN EMPLOYEE CLAIM, HAVE YOU BEEN UNABLE TO WORK?
IF SO, PLEASE COMPLETE 5a

6. ARE YOU WORKING FOR ANOTHER EMPLOYER?
IF YES, PLEASE PROVIDE NAME AND ADDRESS OF OTHER
EMPLOYER.

4a. PLEASE DESCRIBE ACCIDENT OR INJURY

date of injury _____ hour (am-pm) _____ where did injury occur? _____

DESCRIBE DISABILITY/CIRCUMSTANCES: _____

5a. COMPLETE IF TIME LOSS INVOLVED

RESUMED WORK

EXPECTED TO RESUME

first full day unable to work _____ date _____

**THE ATTENDING PHYSICIAN MUST COMPLETE THE
REVERSE SIDE OF THIS FORM.**

DESCRIBE DISABILITY: _____

NOTICE: It is illegal to file a false or fraudulent claim or to knowingly help someone file one. You may be fined or sent to prison for doing so. You may also be required to pay civil damages.

The above answers are true and correct to the best of my knowledge.

7. _____
EMPLOYEE'S SIGNATURE DATE

INSURED AND PATIENT MUST SIGN CONSENT TO RELEASE INFORMATION ON REVERSE SIDE OF FORM.

HEALTH INSURANCE CLAIM FORM

TYPE OR PRINT MEDICARE MEDICAID CHAMPUS OTHER

CONSENT FOR RELEASE OF INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, Veterans Administration Hospital, clinic, other medical or medically related facility, insurance company, consumer reporting agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give to UFCW Union-Employer Health & Welfare Fund or its legal representative, any and all such information.

I UNDERSTAND the information obtained by use of the Authorization will be used by UFCW Union-Employer Health & Welfare Fund or its authorized claims-paying administrator to determine eligibility for benefits or services under the Benefit Plan. Any information obtained will not be released by UFCW Union-Employer Health & Welfare Fund to any person or organization EXCEPT to re-insuring companies, the Medical Information Bureau, Inc., employer, contract holder, or other persons or organization performing business or legal services in connection with my claim, or as may be otherwise lawfully required, or as I may further authorize.

I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of this Authorization be as valid as the original. I AGREE this Authorization shall be valid for two and one-half years from the date shown below.

_____ Date _____ Member's Signature _____ Patient's Signature (if other than a minor child)

PATIENT & EMPLOYEE INFORMATION		
PATIENT'S NAME (First name, middle initial, last name)		PATIENT'S DATE OF BIRTH
MEMBER'S NAME (First name, middle initial, last name)		I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW SIGNED (Member or Authorized Person)
PHYSICIAN OR SUPPLIER INFORMATION		
1. DATE OF CURRENT: MM DD YY ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	2. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	3. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
4. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	4a. I.D. NUMBER OF REFERRING PHYSICIAN	5. Surgery performed _____ 5a. Date _____ Description _____
6. IS ILLNESS OR INJURY DUE TO CLAIMANT'S OCCUPATION? <input type="checkbox"/> Yes <input type="checkbox"/> No		
7. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3, OR 4 TO ITEM 11 BY LINE)		
1. _____	3. _____	
2. _____	4. _____	
8. EXTENT OF DISABILITY		
(a) Is patient now totally disabled for his own occupation? Yes <input type="checkbox"/> No <input type="checkbox"/> Is patient now totally disabled for any other occupation? Yes <input type="checkbox"/> No <input type="checkbox"/>		Date patient disabled Mo. _____ Day _____ Yr. _____
(b) Date patient did or will resume work?		
Regular Occupation Mo. _____ Day _____ Yr. _____	Indefinite <input type="checkbox"/> Never <input type="checkbox"/>	Date of next evaluation Mo. _____ Day _____ Yr. _____
Other Occupation Mo. _____ Day _____ Yr. _____	Indefinite <input type="checkbox"/> Never <input type="checkbox"/>	
(c) If patient will return to work with restriction or limitation, please describe and state how long it will be imposed.		
REMARKS:		
9. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)		
10. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)		
11. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #		
SIGNED	DATE	PIN# GRP#