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.

RETURN IMMEDIATELY

STATEMENT OF CLAIM
TIME LOSS BENEFITS

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

TO BE COMPLETED BY EMPLOYER

Member / Employer to complete
ALL Required Portions

name of employee

$_____
basic weekly earnings

first full day unable to work date

☐ RESUMED WORK
☐ EXPECTED TO RESUME
☐ 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

email address

date of birth sex

occupation local no. social security number

	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.

DESCRIBE DISABILITY: _____

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

first full day unable to work date

☐ RESUMED WORK
☐ EXPECTED TO RESUME

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

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.

[081816]

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 MM DD YY MM DD YY FROM TO

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? ☐ Yes ☐ 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 ☐ No ☐ Date patient disabled *Mo.* _____ *Day* _____ *Yr.* _____

Is patient now totally disabled for any other occupation? Yes ☐ No ☐

(b) Date patient did or will resume work?

Regular Occupation *Mo.* _____ *Day* _____ *Yr.* _____ *Indefinite* ☐ *Never* ☐ Date of next evaluation *Mo.* _____ *Day* _____ *Yr.* _____

Other Occupation *Mo.* _____ *Day* _____ *Yr.* _____ *Indefinite* ☐ *Never* ☐

(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.)

SIGNED DATE

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 #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE