



AUTOMOILE MECHANICS' LOCAL 701 WELFARE FUND

361 S. FRONTAGE ROAD, SUITE 100 | BURR RIDGE, IL 60527

TELEPHONE: (708) 482-0110 | FAX: (708) 482-9140

email: 701claim@mech701-benefits.org

website: www.mech701-benefits.org

PLEASE CHECK IF YOUR ADDRESS HAS CHANGED SINCE YOUR LAST CLAIM

CLAIM FOR SHORT-TERM DISABILITY BENEFITS

PART I MEMBER'S STATEMENT (PLEASE PRINT)

Member's Name		Home Telephone Number ()	Date of Birth / / ____ Male ____ Female	ID#/SS#
		Cell Phone Number ()		
Home Address (Street, City, State, Zip)			Email Address: _____	
Current job title with your employer				
Briefly describe the daily duties of your job				
Date first treated for current condition / /		Name of Physician or Facility		
Is this Disability due to: _____ Motor Vehicle Accident _____ Other Accident/Injury _____ Sickness/Illness _____ Work-related Injury/Sickness _____ Pregnancy				
Please describe your medical condition(s) or injury that is resulting in your disability. When did the symptoms first appear? If related to an accident/injury, state WHEN , WHERE and HOW the injury occurred.				
Are you pursuing reimbursement from ANY other party or insurance carrier in relation to this condition? _____ Yes _____ No If yes, please provide the name, address and telephone number of the other party or insurance carrier.				
Have/will you receive any salary/vacation/sick pay for this period of disability: _____ Yes _____ No If yes, provide specific dates paid by your employer _____/_____/_____ through _____/_____/_____				
IF YOUR CLAIM WAS DENIED BY THE WORKERS' COMPENSATION CARRIER & COMMISSION FORWARD A COPY OF THE DENIAL LETTER(S) WITH YOUR CLAIM				
I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct and complete. I will reimburse the fund for any over-payment made to me or in my behalf due to error or omission on this form.				
_____ SIGNATURE OF MEMBER OR LEGAL REPRESENTATIVE			_____ DATE	
_____ PRINTED NAME OF LEGAL PERSONAL REPRESENTATIVE			_____ RELATIONSHIP TO MEMBER	
WHEN RELEASED TO RETURN TO WORK, PLEASE FAX A COPY OF THE PHYSICIAN'S RELEASE TO 708-482-9140				

PART II ATTENDING PHYSICIAN'S STATEMENT (ALL QUESTIONS MUST BE ANSWERED TO AVOID DELAY)

H I S T O R Y	Name of Patient (Last, First, M.I.)- Please Print _____		Date of Birth _____ / ____ / ____
	Patient's symptoms result from (check all that apply): _____ Employment _____ Illness _____ Auto Accident _____ Other Accident _____ Pregnancy Type of delivery _____ Date Symptoms first appeared _____ / ____ / ____ Expected/Actual Date of Delivery _____ Name and address(es) of other treating physician(s): _____ _____ _____		
	Hospital name: _____		Confinement dates: _____ / ____ / ____ through _____ / ____ / ____
	Diagnoses with ICD10-CM codes: list in decending order of severity (including any complications). Please go to the appropriate assessment section and elaborate. ICD-10 _____ Subjective symptoms: _____ Objective findings: _____		
T R E A T M E N T	Date of first visit: _____ / ____ / ____ Date of last visit: _____ / ____ / ____ Frequency: _____ Weekly _____ Monthly _____ Other		Nature of treatment (including surgery, medications, therapies prescribed, if any): _____ _____ _____
	Specific restrictions and limitations: _____ _____ _____		
	Physical Impairments (as defined in Federal Dictionary of Occupational Titles) _____ Class 1 No limitation of functional capacity; capable of heavy work*. No restrictions. (0-10%) _____ Class 2 Medium manual activity*. (15-30%) _____ Class 3 Slight limitation of functional capacity; capable of light work*. (35-55%) _____ Class 4 Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60-70%) _____ Class 5 Severe limitation of functional capacity; incapable of minimum (sedentary*) activity. (75-100%) Remarks: _____ Mental Impairments (If Applicable) a. Please define "stress" as it applies to this patient _____ b. What stress and problems in interpersonal relations has patient had on the job? _____ Class 1 Patient is able to function under stress and engage in interpersonal relations (no limitations) _____ Class 2 Patient is able to function under stress and engage in interpersonal relations (slight limitations) _____ Class 3 Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations) _____ Class 4 Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations) _____ Class 5 Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations) Remarks: _____		
I M P A I R M E N T S	Is patient now totally disabled? Patient's Job _____ Yes _____ No		Date patient became disabled due to present illness _____ / ____ / ____
	Any Other Work _____ Yes _____ No		
	When do you expect a fundamental or marked change in the future? _____ 1 Month _____ 1-3 Months _____ 3-6 Months _____ Never		If not disabled was patient released to return to work? _____ Yes _____ No _____ Full Duty _____ Restricted Duty
	Patient was continuously disabled (unable to work): From _____ / ____ / ____ To _____ / ____ / ____		If still disabled, date patient should be able to return to work _____ / ____ / ____
	Date of next scheduled appointment: _____ / ____ / ____		
Reason unable to work, in detail: _____ _____ _____			
The above statements are true and complete to the best of my knowledge and belief			
Physician Name (Please Print) _____		Degree/Specialty (must be signed by Medical Doctor - MD or Doctor of Osteopathic - DO) _____	Telephone () _____
Address (Street, City, State, Zip) _____ _____ _____			
Signature _____		Tax Identification # _____	Date _____



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CLAIM FOR SHORT-TERM DISABILITY BENEFITS

PART III EMPLOYER'S STATEMENT (ALL QUESTIONS MUST BE ANSWERED TO AVOID DELAY)

Employer Name		Employer Phone Number ()	
Employer Address (Street, City, State, Zip)			
Employee Name		Employee Social Security Number _____-_____-_____	
		Employee Date of Birth / /	
Actual last day worked ____/____/____ ____ Hours worked	Normal Work Schedule Mon Tues Wed Thurs Fri Sat Sun _____ _____ Hours/Day _____ Hours/Week		
Date Employee Terminated ____/____/____	Reason for leaving work ___ Disability ___ Resigned ___ Terminated ___ Layoff ___ Retired ___ Leave of Absence		
Can the employee's job be modified to allow for return to work? ___ Yes ___ No ___ Maybe, depending on restrictions		Date employee returned to work ____/____/____ ___ Full Time ___ With Restrictions	
Did this Disability arise out of employment? ___ Yes ___ No If yes, please explain			
Has a Workers' Compensation Claim been filed? ___ Yes ___ No			
Will this employee receive sick/leave/vacation pay after their Last Day Worked? ___ Yes ___ No <i>If Yes, complete dates below.</i>			
Date payments begin / /		Date payments end / /	
Employee's Job Title			
Brief description of major job duties			
Please contact the employee's direct supervisor and then CIRCLE the strength demand which best describes the employee's job: S - Sedentary 10 Lbs Maximum lifting, occasional lift/carry of small articles. Some occasional walking or standing required L - Light 20 Lbs Maximum lifting with frequent lift/carry up to 10 Lbs. A job is light if less lifting is involved but significant walking/standing is done or if done mostly sitting but requires push/pull on arm or leg controls. M - Medium 50 Lbs Maximum lifting with frequent lift/carry up to 25 Lbs. H - Heavy 100 Lbs Maximum lifting with frequent lift/carry up to 50 Lbs. V - Very Heavy Over 100 Lbs lifting with frequent lift/carry over 50 Lbs.			
The above statements are true and complete to the best of my knowledge and belief			
Name of person completing form (please print)		Telephone Number ()	
Title of person completing form	E-mail address	Fax Number ()	
Signature		Date Signed	

PLEASE NOTIFY THE FUND OFFICE WHEN THE EMPLOYEE RETURNS TO WORK AT 708-482-0110

**HIPAA AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FOR
SHORT-TERM DISABILITY BENEFITS**

Member Name _____ **ID#** _____ **DOB** _____

Persons/Categories of persons providing the information: Any provider of medical services, insurance company, Social Security Administration, governmental agency, vocational provider or employer having medical information with respect to any physical or mental condition of mine.

I hereby authorize the use or disclosure of my protected health information as described below to the **Automobile Mechanics' Local 701 Welfare Fund**.

Information to be disclosed: All information necessary to allow the Automobile Mechanics' Local 701 Welfare Fund or its representatives to determine my eligibility for short-term disability benefits and to process my disability claim. Such information may include, but is not limited to: Any and all medical/dental records relating to my physical and/or mental health whether for treatment or evaluation purposes, pharmacy records and strength/functional testing.

The sole purpose of this disclosure is for the adjudication of my claim for short-term disability benefits.

I understand the following:

- This authorization is voluntary and I may revoke it at any time by contacting the Automobile Mechanics' Local 701 Welfare Fund but any such revocation will not affect any actions that the Automobile Mechanics' Local 701 Welfare Fund took before receipt of the revocation.
- I may refuse to sign this authorization; however, if I refuse to sign this authorization I may not receive short-term disability benefits under the plan.
- I agree that photocopies of this authorization shall be as valid as the original.
- I may inspect and/or copy the health information described above.
- My medical treatment or payment of medical benefits cannot be conditioned upon whether I sign this authorization.
- If there is a conflict between a prior request for restrictions and this authorization, this authorization controls.
- This authorization is effective from the date signed below until my disability claim ends or 12 months from the date signed below, whichever is earlier.

SIGNATURE OF MEMBER OR LEGAL PERSONAL REPRESENTATIVE

DATE

PRINTED NAME OF LEGAL PERSONAL REPRESENTATIVE

RELATIONSHIP TO MEMBER

**HIPAA AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO THE AUTOMOBILE
MECHANICS' LOCAL 701 PENSION FUND**

In addition to the above authorization, I further authorize the Automobile Mechanics' Local 701 Welfare Fund to release information regarding the duration of this period of short-term disability to the Automobile Mechanics' Local 701 Pension Fund. This authorization is effective for 12 months from the date signed below.

SIGNATURE OF MEMBER OR LEGAL PERSONAL REPRESENTATIVE

DATE

PRINTED NAME OF LEGAL PERSONAL REPRESENTATIVE

RELATIONSHIP TO MEMBER