CLAIM INSTRUCTIONS and FORM

IRON WORKERS DISTRICT COUNCIL OF WESTERN NEW YORK AND VICINITY WELFARE FUND

SUPPLEMENTAL WEEKLY DISABILITY BENEFITS

WHEN TO FILE A CLAIM

Your plan provides weekly disability benefits, and a claim for these benefits should be filed as soon as your absence due to the disability exceeds the waiting period.

HOW TO FILE A CLAIM

1. Have your doctor complete the Attending Physician's Statement on the back of this form.
2. Complete, date and sign the "Statement of Claim" at the bottom of this form. Be sure to complete each item on the form to avoid a delay in the payment of your claim.

NOTE: The Ironworkers District Council of Western N.Y. and Vicinity Welfare Fund may request additional Attending Physician's Statements as necessary.

WHERE TO FILE A CLAIM

Send the completed "Statement of Claim" form (with your doctor's report on the back) to:

IRON WORKERS DISTRICT COUNCIL OF
WESTERN NEW YORK AND VICINITY WELFARE FUND
3445 Winton Place, Suite 238 **Tel: 585-424-3510**
Rochester, NY 14623-2950 **Fax: 585-424-3722**

NOTICE

Your cooperation in completing and providing this information will insure prompt consideration for payment of Disability Benefits. No benefits can be paid until such information is provided.

TO BE COMPLETED BY THE EMPLOYEE

(Be sure to complete each item to avoid a delay in the payment of your claim.)

1. EMPLOYEE NAME _____ DATE OF BIRTH _____ SEX M ☐ F ☐
   First Name Middle Initial Last Name
2. HOME ADDRESS _____ TELEPHONE _____
   No. Street City State Zip Code
3. SOCIAL SECURITY NO. XXX-XX-___ ___ ___ ___ LOCAL #_____
4. EMPLOYER'S NAME AND PHONE#_____
5. HAS YOUR EMPLOYMENT TERMINATED, OR ARE YOU CURRENTLY ON LAYOFF OR ON LEAVE OF ABSENCE? **YES** ☐ **NO** ☐

   If Yes, Explain _____
6. NATURE OF ILLNESS _____ DATE OF FIRST TREATMENT _____
7. IS THIS CLAIM BASED ON AN ACCIDENT? **YES** ☐ **NO** ☐

   If Yes, Give Date _____ 20_____ and Time_____ AM ☐ PM ☐

   Where Did Accident Occur? _____

   How Did Accident Happen? _____
8. ARE ANY OF THE ILLNESSES OR INJURIES FOR WHICH THIS CLAIM IS BEING MADE RELATED TO EMPLOYMENT? **YES** ☐ **NO** ☐
9. HAS A PREVIOUS CLAIM FOR THIS SAME DISABILITY BEEN MADE? **YES** ☐ **NO** ☐

I certify that the information given by me in support of this claim is true and correct.

DATE_____SIGNATURE OF EMPLOYEE _____

THIS FORM SHOULD BE COMPLETED IMMEDIATELY AND RETURNED TO:

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WESTERN NEW YORK AND VICINITY WELFARE FUND
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HEALTH INSURANCE CLAIM – DISABILITY INCOME

PART A **TO BE COMPLETED BY PATIENT (INSURED)**

PATIENT'S NAME AND ADDRESS	DATE OF BIRTH

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment.

PATIENT SIGNATURE

DATE

PART B **ATTENDING PHYSICIAN'S STATEMENT**

DIAGNOSIS CODE AND CONCURRENT CONDITIONS

IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT?
YES ☐ **NO** ☐

DATES OF SERVICES
(IF PREVIOUS FORM SUBMITTED TO THIS CARRIER, YOU NEED SHOW ONLY DATES SINCE LAST REPORT

DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION.	PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? **YES** ☐ **NO** ☐ DATE OF NEXT APPOINTMENT
PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (UNABLE TO WORK) FROM THRU	IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK

DATE PHYSICIAN'S NAME (PRINT) SIGNATURE DEGREE TELEPHONE

STREET ADDRESS CITY OR TOWN STATE OR PROVINCE ZIP CODE