Service. Security. Stability.

Chicago Regional Council of Carpenters Welfare Fund

Instructions for Completing the Weekly Disability Recertification Claim Form

1. **This form is required to be completed in order to continue or end your disability benefit.** If this is your first time filing for disability, you will need to complete the Weekly Disability Claim Form and **not** this form to initiate your claim. The weekly disability benefit plus credit of welfare hours is available only to a carpenter who is currently eligible for benefits **and** who is unable to work in covered employment due to a non-work related illness or injury. Work-related injuries are not eligible for a weekly benefit check, but may be eligible for credit of welfare hours. The carpenter must be under the active care of a physician during the entire period of disability. This weekly disability benefit is not available to a carpenter on the Low Cost Medical Plan, nor is it available to a carpenter's spouse or dependent child.

2. **Complete the Weekly Disability Recertification Claim Form in its entirety.** Print clearly in blue or black ink and answer all questions to Part 1. Have your attending physician complete Part 2. If the form is not legible, if a question is left unanswered or the form has not been signed, it will be returned to you for completion. The Recertification Weekly Disability Claim Form must be signed and dated by you and your physician to be valid. Incomplete forms will be returned for completion and will result in delaying your benefit.

3. **Mail or fax the completed Weekly Disability Recertification Claim Form to:**

   Chicago Regional Council of Carpenters Welfare Fund
   12 East Erie Street
   Chicago, IL 60611
   Fax: 312-951-1515

4. **What happens next?** Within five (5) business days of the Plan's receipt of your Weekly Disability Recertification Claim Form, the Plan will review the information provided on the form to continue your disability benefit. Disability checks are issued every Thursday.

5. **What must I do to maintain my benefit?** If you continue to remain disabled you will be required to complete another Weekly Disability Recertification Claim Form confirming you continue to be under the care of a physician with verification from your physician that you continue to remain disabled. The Plan will send to you another recertification form when needed for completion.

Should you have questions regarding completing this form or your eligibility for this benefit, please contact the Welfare Fund at 312-787-9455, phone option 3. Any one of the Participant Services Representative can assist you Monday through Friday between the hours of 8:00 a.m. and 4:30 p.m.

CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND
12 EAST ERIE STREET • CHICAGO, IL 60611
(312) 787-9455, OPTION 3
FAX: 312-951-1515

* W K D I S R C *

WEEKLY DISABILITY CLAIM FORM - RECERTIFICATION

(Print Clearly)

CLAIM NO. _____

Instructions: The participant must complete Part 1. The attending physician must complete Part 2. Return the completed form (by mail or fax) to the Fund Office. If you fax, please mail the original to the Fund Office. Failure to complete this form in full may result in a delay of payment.

Part 1 – To be completed by Participant

1. Participant's Last Name First Middle Initial	2. Date of Birth / /	3. Soc. Sec. Number or BCBS I.D. Number

4. Participant's Home Address	5. City	6. State	7. Zip Code

8. Telephone Number ( )	9. Cell Phone Number ( )	10. Gender: □ Male □ Female	11. Email Address

12. If you have been treated by physicians other than the one completing this form, please provide their names and phone numbers below:

12(a) Name:	Phone Number: ( )
12(b) Name:	Phone Number: ( )

I hereby authorize any physician, hospital or other medical provider to release to the Chicago Regional Council of Carpenters Welfare Fund (the "Welfare Fund"), or its representatives, any information regarding my health, including but not limited to medical history, medical records from another provider, diagnosis, prognosis, symptoms and treatment of any physical or mental condition relevant to this application. I understand that the Welfare Fund will use this information to determine my claim for benefits. Information includes written, electronic and oral information related to this claim for benefits. Any information received by the Welfare Fund pursuant to this authorization shall be maintained in accordance with applicable privacy laws. This authorization shall expire at the later of (i) one year from the date of your signature or (ii) termination of the period in which you are eligible for Weekly Disability benefits. You have the right to revoke this authorization at any time. A photographic copy of this authorization shall be as valid as the original. I understand that it is fraudulent for me or anyone to knowingly complete this form with false or misleading information or to knowingly omit important facts.

(Claim not valid unless signed by Participant)

13. **Participant's Signature X** Date: / /

Part 2 – To be completed by Attending Physician

1. Patient's Name (Last) (First) (Middle Initial)	2. Patient's Soc. Sec. Number or BCBS I.D. Number	3. Patient's Date of Birth / /

4. Nature of sickness or injury (describe complications, if any)

5. Report of Services (If you have submitted a previous form for this patient, you need only show dates and service since last report.)

Date of Services	Place of Service	Description of Surgical or Medical Services Rendered	Procedure Code – If Used (If code other than CPT used, give name)

6. Patient was continuously **totally** disabled (unable to perform duties of occupation) from: □ n/a or / / through / /	7. Patient was continuously **partially** disabled from: □ n/a or / / through / /

8. Please state whether you are actively supervising the patient's care and, if so, the frequency of visits (*e.g.*, weekly, monthly)

9. If patient was partially disabled, please list restrictions, including weight restrictions:

10. Date Patient is able to return to work: / /

11. Attending Physician's Name:	12. Phone Number: ( )
	13. Fax Number: ( )

14. Attending Physician's Address	15. City	16. State	17. Zip

18. Signature of Physician	19. Physician's Tax Identification Number	20. Date Completed / /

NOTICE TO ALL PARTIES COMPLETING THIS FORM: It is fraudulent to fill out this form with information you know to be false or misleading or to knowingly omit important facts. Criminal and/or civil penalties can result from such an act.