

Construction Industry Welfare Fund of Rockford Time Loss Claim Form <i>Please return this form to:</i> CIWFR Attn: Time Loss 6838 East State Street, Suite 201 Rockford, 61108		<u>Time Loss Benefits</u> <table border="0"> <tr> <td></td> <td><u>Non-Occupational</u></td> <td><u>Occupational</u></td> </tr> <tr> <td>Weekly Benefit:</td> <td>\$350 less FICA/MEDC</td> <td>\$350 less FICA/MEDC</td> </tr> <tr> <td>Max Benefit Period:</td> <td>26 weeks</td> <td>1 week</td> </tr> <tr> <td>Waiting Period:</td> <td>Accident 1st day Illness 8th day</td> <td>1st day</td> </tr> </table>			<u>Non-Occupational</u>	<u>Occupational</u>	Weekly Benefit:	\$350 less FICA/MEDC	\$350 less FICA/MEDC	Max Benefit Period:	26 weeks	1 week	Waiting Period:	Accident 1 st day Illness 8 th day	1 st day
	<u>Non-Occupational</u>	<u>Occupational</u>													
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Max Benefit Period:	26 weeks	1 week													
Waiting Period:	Accident 1 st day Illness 8 th day	1 st day													
For Office Use Only <input type="checkbox"/> Eligible <input type="checkbox"/> Not Eligible		Qualifying Eligibility Hours: 5 hours per day with a max of 100 hours per month for no longer than 6 months (see SPD for lifetime max).													
A. TO BE COMPLETED BY MEMBER (please print)															
Last Name		First Name	MI												
Address															
City	State	Zip	Phone#												
Local Union #	SSN #	DOB	Date Employed												
First full day unable to work		Date returned to work													
Description of Injury or Illness:															
Is disability due to an accident? Yes <input type="checkbox"/> No <input type="checkbox"/>		Date of accident	Time												
Where did accident occur?		Describe accident:													
Is disability due to occupational cause? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, complete Section B															
Have you filed, or do you intend to file for Worker's Compensation? Yes <input type="checkbox"/> No <input type="checkbox"/>															
I hereby authorize any physician, hospital, or other medically related facility, insurance company or other organization, institution or person to release to the Construction Industry Welfare Fund of Rockford and/ or Group Administrators any records or information relating to my claim or any facts concerning my injury illness or treatment.															
Member Signature _____		Date _____													
B. TO BE COMPLETED BY EMPLOYER ONLY IF OCCUPATIONAL															
Employer Name		Phone #													
Address															
City	State	Zip													
Employees Name		Is disability due to occupational cause? Yes <input type="checkbox"/> No <input type="checkbox"/>													
Date (first full day) employee was unable to work:															
Date	<input type="checkbox"/> Resumed work	<input type="checkbox"/> Expected to Resume work	<input type="checkbox"/> Terminated												
Employer Signature _____		Title _____	Date _____												

Attending Physician's Statement must also be completed and returned to the CIWFR address above.

If you have questions regarding your Time Loss, please call GAL at 815-399-0800 or 800-249-7947.

C. ATTENDING PHYSICIAN'S STATEMENT			
1. Name of Patient		DOB	SSN #
2. Diagnosis – Please include the primary diagnosis and list any secondary conditions.			
Patient continuously totally disabled dates (Claim can not be processed without this information)		<u>DISABLED FROM:</u>	<u>DISABLED TO:</u>
Date of Last Examination	Diagnosis (including any complications) include ICD9 and/or DSM IV Multi Evaluation Nomenclature and Code Number		
Objective Findings (including current x-rays, EKGs, psychiatric testing, lab data and clinical findings)			
Symptoms			
Is this condition due to: Accident <input type="checkbox"/> Sickness <input type="checkbox"/>		Date symptoms first appeared or accident occurred:	
Is the accident or sickness related to patient's employment? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>			
Date restrictions and limitations began:		Has patient ever been treated for the same or similar condition? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, state when and describe.	
3. Information About the Patient's Ability to Work – Information is critical to understanding your patient's condition.			
Has patient been released to work in his/her occupation? Yes <input type="checkbox"/> No <input type="checkbox"/> In any occupation? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If patient has demonstrated a loss of function, please provide restrictions and limitations and the date they began in the space provided below.			
Fully describe restrictions and limitations. Restrictions (What the patient should not do)			
Limitations (What patient cannot do)			
If pregnant, expected delivery date		If delivered, actual delivery date	Delivery type: Normal <input type="checkbox"/> C-Section <input type="checkbox"/>
Date of first visit for this illness or injury		Date of next visit	Date of last visit Frequency of visits
Is patient: Ambulatory <input type="checkbox"/> Bed Confined <input type="checkbox"/> House Confined <input type="checkbox"/> Hospital Confined <input type="checkbox"/>		Has patient been admitted to hospital?	
		Confined: From: To:	
If hospital confined, give name and address of hospital:			
Have you completed claim forms regarding this patient for other insurance carriers? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, state date and name of insurance company:			
4. Names and Addresses of Treating Physicians			
Print or type name	Degree	Medical Specialty	Phone Number
Address			
City, State, Zip		SSN # or Employer's ID #	
Signature of Physician		Date	