Fox Valley & Vicinity Construction Workers Welfare Fund Disability Claim Form

Please return this form to:

Group Administrators, Ltd.
953 American Lane, Suite 100
Schaumburg, IL 60173
Fax # 847-519-1979

Time Loss Benefits

Weekly Benefit: $450 less FICA/MEDC

Max Benefit Period: 26 Weeks

Waiting Period: Accident 1st day
Illness 8th day

For Office Use Only ☐ Eligible ☐ Not Eligible

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 No Date of accident Time

Where did accident occur?

Describe accident:

Is this disability due to occupational cause? Yes☐ No☐ If yes, complete section B

Have you filed, or do you intend to file for Worker's Compensation? Yes☐ No☐

I hereby authorize any physician, hospital, or medically realted facility, insurance company or other organization, institution or person to release to the Fox Valley & Vicinity Construction Workers Welfare Fund 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

Employee Name Is disability due to occupational cause? Yes ☐ No ☐

Date (first full day) employee was unable to work:

Date ☐ Resumed work ☐ Expected to Resume work ☐ Terminated

Employer Signature Title Date

Attending Physician's Statement must be complted and returned to the address above.
If you have questions regarding your Time Loss, Please call GAL at 847-519-1880 or 800-323-1683.
C. ATTENDING PHYSICIAN'S STATEMENT
1. Name of Patient DOB SSN #
2. Diagnosis – Please include the primary diagnosis and list any secondary conditions.
Date of Examination
Diagnosis (including any complications) include ICD10 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 ☐ Sickness ☐
Date symptoms first appeared or accident occurred:
Is the accident or sickness related to patient's employment? Yes ☐ No ☐ Unknown ☐
Date restrictions and limiations began:
Has patient ever been treated for the same or similar condition? Yes ☐ No ☐ 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 ☐ No ☐ In any occupation? Yes ☐ No ☐
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 limitation.
Restrictions (What the patient should not do)
Limiations (What patient cannot do)
Patient continuously totally disabled dates (Claim can not be processed without this information)
Disability Date From: Disability Date To:
If pregnant, expected date: If delivered, actual delivery date:
Delivery type: Normal ☐ C-Section ☐
Date of first visit for this illness or injury: Date of next visit:
Date of last visit: Frequency of visits:
Is patient: Ambulatory ☐ Bed Confined ☐ House Confined ☐ Hospital Confined ☐
Has patient been admitted to the hospital?
Have you completed claim forms regarding this patient for other insurance carriers? Yes ☐ No ☐ If yes, state the date and name of insurance company:
4. Names and addresses of treating physicians
Print or Type Name Degree Medical Specialty Phone #
Address
City, State, Zip
Signature pf Physician Date