UFCW NATIONAL HEALTH and WELFARE FUND

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CLAIMANT: READ THE FOLLOWING INSTRUCTIONS CAREFULLY

1. USE THIS FORM IF YOU BECOME SICK OR DISABLED WHILE EMPLOYED.
2. YOU MUST COMPLETE ALL ITEMS OF PART A – THE "CLAIMANT'S STATEMENT." BE ACCURATE. CHECK ALL DATES.
3. BE SURE TO DATE AND SIGN YOUR CLAIM (SEE ITEM 12). IF YOU CANNOT SIGN THIS CLAIM FORM, YOUR REPRESENTATIVE MAY SIGN IT IN YOUR BEHALF. IN THAT EVENT, THE NAME, ADDRESS AND REPRESENTATIVE'S RELATIONSHIP TO YOU SHOULD BE NOTED UNDER THE SIGNATURE.
4. DO NOT MAIL THIS CLAIM UNLESS YOUR HEALTH CARE PROVIDER COMPLETES AND SIGNS PART B – THE "HEALTH CARE PROVIDER'S STATEMENT."
5. YOUR COMPLETED CLAIM SHOULD BE MAILED WITHIN THIRTY (30) DAYS AFTER YOU BECOME SICK OR DISABLED TO YOUR LAST EMPLOYER OR YOUR LAST EMPLOYER'S INSURANCE COMPANY.
6. MAKE A COPY OF THIS COMPLETED FORM FOR YOUR RECORDS BEFORE YOU SUBMIT IT.

PART A – CLAIMANT'S STATEMENT (Please print or Type) ANSWER ALL QUESTIONS

SOCIAL SECURITY NUMBER

1. My name is _____ (First / Middle / Last)

2. My address is _____ (Number / Street / City or Town / State / Zip Code / Apt. No.)

3. Tel. No. _____ 4. My age is _____ 5. Married *(Check one)* ❑ Yes ❑ No

6. My disability is *(if injury, also state how, when and where it occurred)* _____

7. I became disabled on _____ (Month / Day / Year) a. I worked on that day ❑ Yes ❑ No

b. I have since worked for wages or profit ❑ Yes ❑ No If "Yes," give dates _____

8. Give name of last employer. If more than one employer during the last eight (8) weeks, name all employers.

EMPLOYERS			DATES OF EMPLOYMENT		AVERAGE WEEKLY WAGES (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO.	FROM MO. DAY YR.	THROUGH MO. DAY YR.	

9. My job is or was _____ (Occupation) _____ (Name of Union and Local Number, If Member)

10. For the period of disability covered by this claim
    a. Are our *receiving* wages, salary or separatlon pay: . . . . . ❑ Yes ❑ No
    b. Are you *receiving* or *claiming*:
    (1) Workers' Compensation for work-connected disability . . . . . ❑ Yes ❑ No
    (2) Unemployment Insurance Benefits. . . . . ❑ Yes ❑ No
    (3) Damages for personal injury. . . . . ❑ Yes ❑ No
    (4) Benefits under the Federal Social Security Act for long-term disability . . . . . ❑ Yes ❑ No
    IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 10a OR 10b, COMPLETE THE FOLLOWING:
    I have ❑ received ❑ claimed from _____ for the period _____ (Date) to _____ (Date)

11. I have received disability benefits for another period or periods of disability within the 52 weeks immediately before my present disability began: . . . . . ❑ Yes ❑ No
    If "Yes," fill in he following: I have been paid by _____ From _____ (Date) To _____ (Date)

12. I have read the instructions above. I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled; and that the foregoing statements, including any accompanying statements, are to the best of my knowledge true and complete.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO FINES AND IMPRISONMENT.

Claim signed on _____ (Date) _____ (Claimant's Signature)

If signed by other than claimant, print below: name, address, and relationship of representative.

HEALTH CARE PROVIDER MUST COMPLETE PART B ON REVERSE

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

IMPORTANT: USE THIS FORM ONLY WHEN THE CLAIMANT BECOMES SICK OR DISABLED WHILE EMPLOYED

PART B – HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type)
THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY AND THE FORM *MAILED TO THE INSURANCE CARRIER OR SELF-INSURED EMPLOYER, OR RETURNED TO THE CLAIMANT WITHIN SEVEN DAYS* OF THE RECEIPT OF THE FORM. For item 7d, give approximate date. Make some estimate. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date under "Remarks."

1. Claimant's Name _____ 2. Age _____ 3. ❑ Male ❑ Female
4. Diagnosis/Analysis _____ Diagnosis Code _____
   a. Claimant's Symptoms _____
   b. Objective Findings _____
5. Claimant hospitalized? ❑ Yes ❑ No From _____ To _____ CPT Code _____
6. Operation indicated? ❑ Yes ❑ No a. Type _____ b. Date _____
7. Enter dates for the following:

	Month	Day	Year
a. Date of your first treatment for this disability.....			
b. Date of your most recent treatment for this disability.....			
c. Date claimant was unable to work because of this disability.....			
d. Date claimant will be able to perform ususual work..... (Even if considerable question exists, estimate date. Avoid use of terms, such as unknown or undetermined.)			

8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease?
   ❑ Yes ❑ No If "Yes," has form C-4 been filed with the Worker's Compensation Board? ❑ Yes ❑ No
   Remarks: (attach additional sheet, if necessary) _____
   (If disability is pregnancy related, please enter estmated delivery date.)

I affirm that I am a	❑ Chiropractor ❑ Dentist	❑ Physician ❑ Podiatrist	❑ Psychologist ❑ Nurse-Midwife	Licensed in the State of	License Number

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL, STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO FINES AND IMPRISONMENT.

Health Care Provider's Signature _____ Date _____
Health Care Provider's Name *(Please Print)* _____ Tel. No. _____
Office Address _____
Number Street City or Town State Zip Code

Employer's Statement Policy Number: _____
Employee's Full Name *(as shown on Social Security card)*: _____ S.S. Number: _____
Employee's Address: _____ Date of Birth: _____
Employee's Occupation: _____ Date Employed: _____ ❑ Full Time ❑ Part Time
Is employee a Union member? ❑ Yes ❑ No Check days normally worked:
If "Yes," is employee eligible for Union benefits? ❑ Yes ❑ No

Mon	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.

If Part Time, give particulars: _____
Date employee last worked: _____
Date employee returned to work: _____
Were wages continued during disability? ❑ Yes ❑ No
Were wages Sick pay? ❑ Yes ❑ No From: _____ To: _____
Were wages Vacation pay? ❑ Yes ❑ No From: _____ To: _____
Is reimbursement requested? ❑ Yes ❑ No
Is disability due to job? ❑ Yes ❑ No
If "Yes," has a compensation claim been filed? ❑ Yes ❑ No
Indicate Weekly Value of Board, Lodging and Tips: _____
Employer's Name: _____
Employer's Identfication No.: _____

EARNINGS 8 WEEKS PRIOR TO DISABILITY
(Including the week in which the disability began)

Month	Day	Year	No. Days Worked	Amount
			Total	

Is this employee currently covered by Social Security? ❑ Yes ❑ No If "No," state grounds for exemption: _____

Address: _____ Telephone No. _____
Signed by: _____ Title: _____ Date _____