Short-Term Disability Claim Application

Mid-America Carpenters Regional Council Health Fund (Fund)
Northern Illinois Region
12 E. Erie St, Chicago, IL 60611
Phone: (312) 787-9455, option 3 | Fax: (312) 337-6496 | Email: submit@macbenefits.org

This application is for the initial filing of a short-term disability claim. If you are filing to continue or end an existing disability claim, you must complete a *Short-Term Disability Claim Recertification*.

Are you eligible to file a claim for short-term disability benefits?

The following criteria must all be met in order to be eligible for short-term disability benefits:

☐ I am the carpenter (short-term disability benefits are not available to spouses or dependents).

☐ My disability is due to a non-work-related illness or injury.

☐ The date on which I became disabled was during an insurance quarter in which I was eligible for health benefits (short-term disability benefits are not available to carpenters covered under COBRA or the Low Cost Plan).

☐ I was under the active care of a licensed physician during the entire period of my disability.

☐ I am not currently receiving a Pension Plan benefit.

If any of the boxes above are not checked, you have not met the criteria to be eligible for short-term benefits.
If this is the case for you, do not complete this application, call a representative at (312) 787-9455, Opt 3 to discuss options.

If ALL the boxes above are checked, complete Parts 1 – 4 in full; your physician must complete Part 5.
Failure to complete this application in full will result in processing delays and possible delay of payment

SECTION 1: PARTICIPANT INFORMATION

Participant Last Name	Participant First Name	Participant Middle Name	UID

Participant Home Address	City	State	Zip

Participant Preferred Phone Number	Email Address	Date of Birth

Did you receive any compensation from your employer, such as holiday, vacation, or sick pay after you were deemed disabled by your physician?

☐ YES ☐ NO. If YES, when was the last paid date? _____

SECTION 2: EMPLOYER INFORMATION

Name of Employer	Employer Phone Number

Mailing Address (if different from the member)	Date Hired

SECTION 3: DISABILITY DETAILS

Date Disability Occurred	Date First Treated for this Disability	Were you first treated in an Emergency Room? ☐ Yes ☐ No

How and where did the illness, injury, or accident related to the disability occur?

List all conditions/symptoms related to this disability:

Is the disability the result of a work-related illness, injury, or accident? ☐ Yes* ☐ No

If YES, have you filed or do you intend to file a claim under Workers' Compensation? ☐ Yes ☐ No ☐ NA

Is the disability the result of an injury due to an accident? ☐ Yes ☐ No	If YES, provide date/time of accident:		
If YES, was a third-party involved in the accident? ☐ Yes ☐ No ☐ NA	Name of Third-Party	Third-Party Mailing Address: Street, City, St, Zip	Third-Party Phone Number
Have you been unable to work as a result of this disability? ☐ Yes ☐ No	If YES, on what date did you last work?	If NO, will you resume work? ☐ Yes ☐ No Return to Work Date (if applicable): _____	

What type of work do you normally do? (check only one)

☐ **HEAVY** work activity – no limitations of functional capacity.
☐ **MEDIUM** work activity – exerting force of 20-50 lbs. occasionally and/or 10-25 lbs. frequently and/or >0-10 lbs. constantly.
☐ **LIGHT** work activity – exerting force of up to 20 lbs. occasionally and/or up to 10 lbs. frequently.
☐ **SEDENTARY** work activity – moderate limitation of functional capacity; exerting force of up to 10 lbs. occasionally. Sedentary work involves sitting most of the time but may involve walking or standing for brief periods of time.

SECTION 4: SIGNATURE

I have read and understand all of the requirements for filing a claim for short-term disability. I do hereby attest that the information provided by me on this application is true, accurate, and complete to the best of my knowledge. I understand that it is fraudulent for me or anyone representing me to knowingly complete this application with false or misleading information or to knowingly omit important facts and that criminal and/or civil penalties can result from such acts.

X

Signature of Participant or Authorized Representative**

Date

Printed Name of Authorized Representative

Relationship to Participant

*For **Workers' Compensation** Cases, if you are filing for credit of disability health hours for a work related injury or illness that occurred more than 12 weeks ago, you are required to **provide copies of all your Workers' Compensation loss wage TTD check stubs with this application or you may submit a ledger or benefit summary letter from the Worker's Compensation carrier that details all loss wage benefits paid to you.**

**If someone else is completing this form on your behalf, you must attach documentation that confirms that the individual is authorized to act on your behalf.

SECTION 5: AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION (PHI)

I authorize any medical professional, hospital or other medical care institution, insurance support organization, pharmacy, government agency, insurance company, employer group policyholder, or benefit plan administrator to release to the Mid-America Carpenters Regional Council (MACRC) Health Fund (Fund), its representative or entity acting on its behalf, any information about the medical advice, care/treatment provided to me, including but not limited to medical history, medical records from another provider, diagnosis, prognosis, symptoms/treatment of any physical or mental condition related to this application, and any employment-related information. The information will be used to assess my claim for Weekly Disability Benefits. Any information obtained that is subject to applicable privacy laws will not be released by the Fund to any person or organization except to re-insuring companies, the Medical Information Bureau, Inc., my employer, group policyholder or other persons or organizations performing business or legal services in connection with my claim, or may be otherwise lawfully required or as I may further authorize. In the event I collect Weekly Disability benefits as a result of an illness, accident or injury, I hereby authorize the Fund to release information of any weekly disability payments to the MACRC Pension or Millmen Pension Funds as needed to credit hours to my work history for use in calculation of my future pension benefits. If I apply and am approved for a Disability Pension, I understand that I cannot receive Weekly Disability benefits and a Disability Pension for the same period of time. I acknowledge that if I am approved for a Disability Pension, I will not be able to receive more than six (6) days of a Weekly Disability benefit if eligible, in any month in which I receive my first monthly benefit under the Pension Plan. If my Disability Pension is approved and paid during the same period of my Weekly Disability benefit, I agree to reimburse the Fund for benefits paid up to the amount of my pension benefits. Recovery of such amount may be made through, but is not limited to, an offset or reduction of any future benefits I may be entitled to receive from the Fund or Pension Funds. I understand that:

- *This authorization is voluntary and I may refuse to sign it.* ☐ ***Check here if you refuse to sign**.*
- *I have the right to revoke this authorization at any time before its expiration date by sending a written notice to each entity that I previously authorized to disclose the information. The revocation will not have any effect on any actions the entity took before it received the revocation notice.*
- *I am not required to sign this authorization as a condition to receive treatment or payment for healthcare, enroll in a health plan, or establish health benefit eligibility.*
- *The information used or disclosed pursuant to this authorization may be redisclosed by the receiving person or organization and, upon redisclosure, may no longer be protected by federal privacy laws.*
- *I, or my representative, will receive a copy of this information upon request. A photographic copy of this authorization is as valid as the original.*
- *This authorization expires at the later of one year from the date of your signature or termination of the period in which you are eligible for Weekly Disability benefits.*
- *Weekly Disability benefits can't be paid unless all sections of this application are completed by me and my medical doctor and only if I am eligible to receive a benefit.*

X

Signature of Participant or Authorized Representative

Date

SECTION 6: TO BE COMPLETED BY PARTICIPANT'S ATTENDING PHYSICIAN

Patient Full Name	Patient BCBSIL ID	Patient DOB

Attending Physician Full Name	Specialty / Credentials

Mailing Address	City	State	Zip

Office Phone Number	Office Fax Number	Tax ID Number

Nature of disability (describe complications, if any)

Symptoms and severity, include date symptoms began:

Has the patient ever had the same or similar condition? ☐ Yes ☐ No, **if YES**, state when and describe:

Is the disability the result of job activity? ☐ Yes ☐ No

Primary Diagnosis of Disability	ICD 10
Secondary Diagnosis of Disability	ICD 10
Other Diagnosis or Complication	ICD 10

Treatment summary including frequency of medical appointments:

Primary Procedure	Primary CPT Code	Procedure Date
Secondary Procedure	Secondary CPT Code	Procedure Date
Other Procedure	Other Procedure CPT Code	Procedure Date

Medications (if any) including dose, frequency, possible side effects/impairments:

Date of Next Appointment:

For medical reasons, the patient cannot perform their job duties and will need to be absent from work as a result of this disability: ☐ Yes ☐ No	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)

Patient is currently able to complete:

☐ **HEAVY** work activity – no limitations of functional capacity.

☐ **MEDIUM** work activity – exerting force of 20-50 lbs. occasionally and/or 10-25 lbs. frequently and/or >0-10 lbs. constantly.

☐ **LIGHT** work activity – exerting force of up to 20 lbs. occasionally and/or up to 10 lbs. frequently.

☐ **SEDENTARY** work activity – moderate limitation of functional capacity; exerting force of up to 10 lbs. occasionally. Sedentary work involves sitting most of the time but may involve walking or standing for brief periods of time.

☐ **NO ABILITY TO WORK.** Patient is completely disabled. Severe limitation or functional capacity, incapable of minimum activity.

☐ **OTHER.** Please explain:

Do you anticipate a return to work without restrictions? ☐ Yes ☐ No	If YES, provide date

Objective findings that substantiate impairment (labs, physical/mental status examination, other testing):

Subjective findings that substantiate impairment:

Referring Physicians (if any):

Referring Physician One	Specialty	Office Phone
Referring Physician Two	Specialty	Office Phone
Referring Physician Three	Specialty	Office Phone

I do hereby attest that the information provided by me on this application is true, accurate, and complete to the best of my knowledge. I understand that it is fraudulent for me to knowingly complete this application with false or misleading information or to knowingly omit important facts and that criminal and/or civil penalties can result from such acts.

X

Signature of Attending Physician **Date**

SECTION 7: AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION (PHI)

BEFORE YOU SUBMIT YOUR CLAIM APPLICATION, please check the following:

☐ I have read the rules for short-term disability claims and all the criteria on the top of page 1 currently apply to me.

☐ I have completed Section 1, 2, 3, 4, and 5 in full.

☐ My physician has completed Section 6.

Special circumstances:

☐ I have a **Workers' Compensation** claim and have attached paystubs or payment ledgers with this application.

☐ An **Authorized Representative** completed and signed this application on my behalf, as such I have attached the required Authorized Representative Form that confirms that this Representative is authorized to act on my behalf.

☐ If your physician has indicated that you are able to perform **Light or Medium duties** but there is no light or medium duty available to you from your employer, a corroborating statement from your employer is required.

Submit completed Disability Application with copies of all required documents:

- **MAIL**: 12 E. Erie, St., Chicago, IL 60611
- **DROP-OFF**: 12 E. Erie, St., Chicago, IL 60611 *or* 4979 Indiana Ave, Lisle, IL 60532
- **Email**: submit@macbenefits.org
- **Fax**: (312) 337-6496

Frequently Asked Questions (FAQs)

When do payments start? Generally disability checks and/or credit of health hours are issued within 5-15 business days of the Fund Office's receipt of all documentation needed to process the claim. Disability checks are issued on Thursdays.

How do I extend my disability period beyond my initial request? You will be required to have your attending physician complete a Recertification Claim Form for Illness or Injury benefits verifying that you continue to be under the care of a physician and you are still disabled. The Fund Office will send to you the recertification form when required. You may also download a form from the Fund's website at www.carpenterbenefits.org. Under Health Plan," select "Forms." Scroll down to "Short Term Disability Claim-Recertification" form.

What about Federal Taxes? You are liable for the taxes on the benefits. If you want us to withhold tax, you may download a form from the Fund's website at www.carpenterbenefits.org. Under "Health Plan," select "Forms", scroll down to "Short Term Disability Claim Form" and click on "IRS Form W-4S." We are required to send a report to your employer at the end of each calendar year with your name, total amount of benefits paid to you, total amounts withheld if any, and your social security number.

Additional Questions? Please contact the Health Fund at (312) 787-9455, option 3. A Participant Services Representative can assist you Monday through Friday between the hours of 8:00 a.m. and 4:30 p.m.

Fund Office Use Only

Date Application Received	By:	Related Disability Claim filed? ☐ Yes ☐ No	Worker's Compensation Claim? ☐ Yes ☐ No If YES, was the required documentation received? ☐ Yes ☐ No
Application competed and signed by Authorized Rep? ☐ Yes ☐ No		If YES, was the required documentation received? ☐ Yes ☐ No / Credentials	
All required information received from **Participant**? ☐ Yes ☐ No If no, what **Participant** info is missing: Letter /Email Sent for missing **Participant** info. Date: _____		All required information received from **Physician**? ☐ Yes ☐ No If no, what **Physician** info is missing: Letter/Email Sent for missing **Physician** info. Date: _____	
Eligibility Quarter in which disability incurred:	Participant Eligibility Status on date of disability: ☐ Active ☐ Self-Pay	Is primary diagnosis covered under the Active Plan? ☐ Yes ☐ No	
Is a claim on file supporting medical appointment(s)? ☐ Yes ☐ No	Previous unrelated Disability Claims? ☐ Yes ☐ No	Disability result of an accident? ☐ Yes ☐ No	
Disability Claim: ☐ **Approved** ☐ **NOT Approved**, reason: _____			