Chicago & Vicinity Laborers' District Council
Health & Welfare Fund • Retiree Health & Welfare Fund

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PARTICIPANT LOSS OF TIME/ACCIDENT CLAIM FORM

Failure to complete this form in full may result in delay of payment of your claims.

SECTION 1: TO BE COMPLETED BY THE PARTICIPANT

PARTICIPANT INFORMATION

Participant's Name: ____ Participant's Alt. ID: ______________
Home Address: ____
City, State, Zip Code: ____ Phone: __________________
Date of Birth: _______________ Male ☐ Female ☐ Local Union Number: __________
Employer's Name: ____ Employer's Phone: __________________
Employer's Address: ____
City, State, Zip Code: ____ Date Employed: _____________________

INFORMATION ABOUT YOUR TIME LOSS CLAIM

Diagnosis: «Free form for diagnosis» ____
Is this illness or injury due to an accident? Yes ☐ No ☐
Have you filed or do you intend to file this claim under Worker's Compensation? Yes ☐ No ☐
Is this a work related illness or injury? Yes ☐ No ☐
Date of Accident: _______________ Where did accident occur? ____
Provide a description of how the illness/injury occurred and include a list of your injuries/disabilities:

____

Who was the party responsible for the accident?
Name: ______________________________________ Address: _______________________________________
City, State, Zip Code: ____
Do you plan to seek reimbursement from the other party? Yes ☐ No ☐
Do you have or intend to hire an attorney for this accident? Yes ☐ No ☐
If yes, please provide your attorney's name, address, and phone number:

____

If no, please be advised that you are required to notify the Fund Office should you hire an attorney in the future.

Have you been unable to work as a result of this illness/injury? Yes ☐ No ☐
What was the first full day you were unable to work? ____________________________
What was the last day that you actually worked? ____________________________
Do you wish to collect Loss of Time Benefits? Yes ☐ No ☐ **(If yes, page 2 must also be completed and returned.)**
Have you resumed work? Yes ☐ No ☐ Do you expect to resume work? Yes ☐ No ☐

The above answers are true and correct to the best of my knowledge.

Participant's Signature: ___________________________________ Date: _____________________

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

SECTION 2: TO BE COMPLETED BY THE ATTENDING PHYSICIAN

Patient's Name: _____ Age: _____
Nature of sickness or injury. (Describe complications, if any.):

_____

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

Dates of Services	Place of Services	Description of Surgical or Medical Services Rendered	ICD10 Codes	Procedure Code- If Used (If code other than CPT* used, give name)

*CPT – Current Procedure Terminology (current edition)

Patient was continuously totally disabled from _____ through _____.

Patient was partially disabled from _____ through _____.

If patient was partially disabled, please list weight restrictions. _____ (lbs.)

Doctor's Name: _____ TIN No.: _____
(Please Print or Type Doctor's Name) (Taxpayer Identification Number)

Doctor's Address: _____ Phone: (___)_____

City, State, Zip: _____

Doctor's Signature: _____ Date: _____
(Personal Signature of Attending Physician)

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SECTION 3: TO BE COMPLETED BY THE PARTICIPANT

I understand that weekly loss of time benefits will not be paid until **all sections** of this form are completed by me and my medical doctor as indicated. I understand that it is fraudulent for me or anyone to complete this form with false information or to knowingly omit important facts. Civil and criminal penalties may result from such an act.

In the event that I collect Loss of Time Weekly Income Benefits as a result of an accident or injury, I hereby authorize the Laborers' Welfare Fund to release information of any weekly benefit payments to the Laborers' Pension Fund as necessary 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 Loss of Time Weekly Income Benefits and Disability Pension Benefits for the same period of time. I acknowledge that if I am approved for a Disability Pension within the first 26 weeks of my disability period, my pension benefits will commence after the 26th Weekly Income Benefit payment. If my Disability Pension is approved and paid during the same period or portion of the period of Extended Weekly Income Benefits (weeks 26 through 52), I agree to reimburse the Laborers' Welfare Fund for benefits paid up to the amount of my pension benefits.

Participant's Signature: _____ Date: _____

Please refer to your Summary Plan Description Pages 32 through 33 for more specific information on Loss of Time Weekly Income Benefits and Extended Weekly Income Benefits. If you have any questions regarding this form or your benefits, please contact the Claims Department at (708) 562-0200.