LABORERS' PENSION FUND and HEALTH and WELFARE
DEPARTMENT of the CONSTRUCTION and GENERAL
LABORERS' DISTRICT COUNCIL of CHICAGO and VICINITY
11465 CERMAK ROAD
WESTCHESTER, ILLINOIS 60154
PHONE: 708-562-0200

PARTICIPANT LOSS OF TIME/ACCIDENT CLAIM FORM

Failure to complete this form in full may result in delay of payment of your claims.
Be sure to have your physician complete Section 2 of this form.

SECTION 1:TO BE COMPLETED BY THE EMPLOYEE

EMPLOYEE INFORMATION:

Name: _____ Social Security No.: _____

Home Address: _____

City, State, Zip: _____ Phone: (____)_____

Date of Birth: _____ Male ☐ Female ☐ Local No.: _____

Employer's Name: _____Employer's Phone: (___)_____

Employer's Address: _____

City, State, Zip: _____Date Employed: _____

INFORMATION ABOUT YOUR TIME LOSS CLAIM

Is the illness or injury due to your work? Yes ☐ No ☐
If you have suffered an injury, was it due to an accident? Yes ☐ No ☐
If yes, provide details: Date of Accident: _____ Time of Accident: _____

Where did accident occur? _____

Give history of the accident: _____

_____

Provide a list of your injuries and/or illnesses: _____

Who was the party responsible for the accident?

Name: _____ Address: _____

_____ Phone (___) _____

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, pages 2 must be completed and returned.)

Have you resumed work? Yes ☐ No ☐ Do you expect to resume work? Yes ☐ No ☐

Have you filed or do you intend to file this claim under Worker's Compensation? Yes ☐ No ☐

If no, do you plan to seek reimbursement from the other party? Yes ☐ No ☐

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

Employees' Signature: _____ Date: _____

«AlternateID»

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	ICD9 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.