CENTRAL STATES SOUTHEAST AND SOUTHWEST AREAS HEALTH AND WELFARE AND PENSION FUNDS

LOSS OF TIME CLAIM FORM - INITIAL REPORT OF DISABILITY

Return Completed Form To: PO Box 5107 Des Plaines IL 60017-5107
or
Fax Form To: 847-518-9757

SECTION 1 - MEMBER'S STATEMENT PLEASE PRINT		
Member ID:	Member's Full Name:	Date of Birth:
Member's Complete Address:		Employer:
If accident related, please answer the following questions:	Date of accident:_____	Where did the accident occur? circle one ○ Home ○ Work ○ Auto ○ Other
Is your disability in any way work related? Yes □ No □ If yes, please explain:		
If you have been denied by Workers' Compensation, attach a copy of the denial and a notarized statement of whether or not you intend to appeal		
Authorization: I hereby authorize any doctor, hospital, or insurance company to furnish and disclose all known facts.		
_____ Signature of Member	_____ Member's Phone Number	_____ Date

SECTION 2 - PHYSICIAN'S STATEMENT PLEASE PRINT		
Patient's Name:	Date disability began: _____ **Do not submit form before this date**	ICD•9 Code or Description:
All dates of treatment for this disability:	Surgery date and procedure performed:	
Was patient hospitalized? Yes □ No □ Date:_____	What is the treatment plan? For a pregnancy, please give the estimated delivery date:_____	Is condition due to patient's employment? Yes □ No □ Briefly explain:
ACTUAL OR ESTIMATED RETURN TO WORK DATE REQUIRED **Actual** return to work date: _____ **OR** **Estimated** return to work date: _____		
Physician's Signature:	Print Physician's Name:	Physician's Phone Number: Date form completed:

SECTION 3 - EMPLOYER'S STATEMENT	
What was the employee's last day of work? _____ (Do not include vacation days)	What date did the employee actually return to work? _____ (Do not use a future date)
Was the employee on layoff? Yes □ No □ Date of layoff: _____	Has a claim been filed for Workers' Compensation related to this disability? Yes □ No □
Employer Signature: _____ Printed Name: _____ Position: _____	
Employer Phone Number: _____ Date form completed:_____	

When do you start to earn Loss of Time Benefits?

If you are injured: Loss of Time is payable from the date the doctor first disables you, if you have received medical treatment within 1 day before or 3 days after your disability date. Otherwise, the first date of medical treatment after your disability began will be used to start your Loss of Time Benefits.	**If you are ill or pregnant:** Loss of Time is payable on the 8th day after the doctor disables you, if you have received medical treatment within 1 day before or 3 days after your disability date. Otherwise, Loss of Time will begin 8 days after you receive medical attention.

Please refer to the Roadmap for Health and Welfare Benefits or the Plan Document, Section XII, for additional Loss of Time Benefits provisions. Included are the weekly rates of payment and the maximum number of weeks payable. You may also visit our website at **www.centralstates.org.**

CHECKLIST FOR COMPLETION OF THE LOSS OF TIME CLAIM FORM
Loss of Time Benefits may be delayed if the form is not completed in FULL.

MEMBER'S STATEMENT - DID YOU:

- ❑ Provide your Member ID Number?
- ❑ Give the accident date and details?
- ❑ Indicate if the disability is work related?
  (If yes, submit the Workers' Compensation denial and a notarized statement of whether or not you intend to appeal.)

PHYSICIAN'S STATEMENT - DID THE PHYSICIAN:

- ❑ Provide the disability date?
- ❑ List all dates of treatment after your disability date?
- ❑ Include your plan of treatment?
- ❑ Give an actual or estimated release date for returning to work?
  (If left blank or stated as unknown, payments will be affected.)

EMPLOYER'S STATEMENT - DID THE EMPLOYER:

- ❑ Provide your actual last day worked?
- ❑ Give the date that you returned to work?
  (The date should only be given if you actually returned to work.)

Please call 1-800-323-5000 if you return to work prior to the date given by your doctor.

Once Loss of Time benefits begin, we will notify you of the date payments end. For consideration of additional Loss of Time benefits, please submit a Continuation Form. To obtain a Continuation Form, contact our Toll-Free Department at 1-800-323-5000 or visit our website at **www.centralstates.org.**

UPS members: If you exhaust your 26 weeks of Loss of Time Benefits, you may be eligible for a long-term disability benefit through UPS. To determine your eligibility, please call 1-877-638-4877.

Non-UPS members: If you exhaust your 26 weeks of Loss of Time Benefits, you may be eligible to make Self-Payments or receive an Extension of Benefits to continue health and welfare coverage. Please contact our Toll-Free Department at 1-800-323-5000 if you need further information.

Print Form