SHEET METAL WORKERS' LOCAL UNION NO. 73
WELFARE FUND

4530 ROOSEVELT ROAD
HILLSIDE, IL 60162-2053
708-449-7373

CSMCA

WEEKLY INDEMNITY–INITIAL FORM

ALL QUESTIONS MUST BE ANSWERED, PLEASE PRINT. RETURN COMPLETED CLAIM FORM TO THE FUND OFFICE.

MEMBER'S STATEMENT OF CLAIM FOR GROUP ACCIDENT AND HEALTH BENEFITS

I HEREBY APPLY FOR BENEFITS ON ACCOUNT OF TOTAL DISABILITY WHICH IS IN NO WAY CONNECTED WITH OR DUE TO MY EMPLOYMENT.

1. DATE TOTAL DISABILITY COMMENCED?	DATE TOTAL DISABILITY CEASED?
2. LAST DATE OF WORK	NAME OF COMPANY
3. IS CLAIM DUE TO AN ACCIDENT? ☐ YES ☐ NO	IF "YES," WHERE DID ACCIDENT OCCUR? / DATE OF ACCIDENT
DESCRIBE ACCIDENT:	
4. IS THIS CLAIM THE RESULT OF A WORK RELATED ILLNESS OR INJURY? ☐ YES ☐ NO	

5. EMPLOYEE'S NAME (PLEASE PRINT)	SOCIAL SECURITY NUMBER	AGE	SEX	MARITAL STATUS
6. SIGNATURE OF EMPLOYEE		HOME PHONE		DATE
7. STREET NO.	CITY	STATE		ZIP CODE

TO BE COMPLETED BY PATIENT	AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment.	EMPLOYEE'S SIGNATURE / DATE

AUTHORIZATION TO RELEASE INFORMATION TO LOCAL 73 PENSION FUND

I authorize the Sheet Metal Workers' Local 73 Welfare Fund to disclose my health information to the Sheet Metal Workers' Local 73 Pension Fund for the purposes of paying any benefits including a Disability Pension or Disability Benefits. This authorization expires 60 days after my Disability Pension or Disabiltiy Benefits begin. I understand that I may revoke this authorization in writing at any time and that the health information held by the Pension Fund may not be considered protected health information. Treatment, payment, and eligiblity will not be conditional upon receipt of an authorization.

Insured's Signature _____ Date _____

ATTENDING PHYSICIAN'S STATEMENT

DIAGNOSIS AND CONCURRENT CONDITIONS:		
IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT ☐ YES ☐ NO	PREGNANCY? ☐ YES ☐ NO	IF YES APPROXIMATE DATE PREGNANCY COMMENCED DATE
DATES OF SERVICES (IF PREVIOUS FORMS SUBMITTED TO THIS CARRIER, YOU NEED SHOW ONLY DATES SINCE LAST REPORT)		
DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED.	DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION	
PLEASE GIVE DATE OF DISABILITY AND APPROXIMATE DATE WHEN MEMBER WILL BE ABLE TO RETURN TO WORK FROM THRU	DATE MEMBER RETURNED TO WORK	

DATE	PHYSICIAN'S NAME (PRINT)	SIGNATURE	DEGREE	TELEPHONE
STREET ADDRESS	CITY OR TOWN	STATE OR PROVINCE		ZIP CODE

NOTE TO MEMBER:

IT IS YOUR RESPONSIBILITY TO NOTIFY THE FUND OFFICE UPON PHYSICIAN'S RELEASE TO RETURN TO WORK.

IF YOU FAIL TO NOTIFY THE FUND OFFICE OF YOUR RETURN TO EMPLOYMENT DATE, YOU WILL BE RESPONSIBLE TO REIMBURSE THE LOCAL, IN FULL, FOR ANY MONIES PAID TO YOU AFTER YOUR RETURN DATE.

IT MAY BECOME NECESSARY FOR THE FUND OFFICE TO SEND A FORM TO YOU FROM TIME TO TIME CONFIRMING YOUR DISABILITY. THIS FORM MUST BE COMPLETED BY YOU AND YOUR PHYSICIAN AND RETURNED TO THE FUND OFFICE IN ORDER THAT YOUR BENEFITS MAY CONTINUE.

PLEASE SIGN: _____
MEMBER'S SIGNATURE