CLAIM FORM – DISTRICT NO.9, WELFARE TRUST — Weekly Benefits Only

SECTION I — TO BE COMPLETED BY EMPLOYEE

Member Name:

____________ Last   ____________ First   ____ MI

Member ID #:

Home Address:

________________________ Street

____________ City   ______ State   ______ Zip

Home Phone:

Date of Birth: ____/____/____

Male   Female

Employer:

Date You Returned To Work   or Date You Expect to Return

Date accident happened or illness began ____________________

Describe injuries received or nature of illness ____________________

____

If accident, where and how did it happen? ____________________

Has any other form been filed with regard to this accident or illness? No   Yes

Is this the result of a motor vehicle accident? No   Yes

Was injury or illness caused by your work? No   Yes

Is or was patient hospital confined? No   Yes*

*If yes, where? ____________________

If accident send copy of Hospital Emergency Room Report with claim form.

I CERTIFY THAT THE FOREGOING STATEMENTS ARE TRUE AND COMPLETE TO MY KNOWLEDGE

I authorize the release of any medical information necessary to process this claim.	Member's Signature	Date

SECTION II — TO BE COMPLETED BY PHYSICIAN

1. Diagnosis: ____________ Please use ICD10 Codes: ____________

2. How long will patient be unable to work? From ____________ thru ____________

3. It is estimated the patient will be able to return to work on ____________

4. Date of first office visit for this disability ____________

5. Was injury or illness work related? ○ No ○ Yes

6. Was patient first seen by you in hospital? ○ No ○ Yes If yes, date? ____________

7. Did the patient have surgery? ○ No ○ Yes If yes, please use CPT code ____________

REMARKS:________________________

____

Date	Doctor's Signature with Degree	Phone Number
FEIN	Doctor's Name (Printed)	

Address	City	State	Zip

SECTION III — TO BE COMPLETED BY EMPLOYER

Company Name	Address	City	State	Zip

State Last Day Employee Worked   Date:

Has employee returned to work? ○ Yes   Date Returned: ○ No   When expected to return?

Has employee made a claim for Worker's Compensation? ○ No ○ Yes   Is employee entitled to such benefits? ○ No ○ Yes

If a Worker's Compensation claim has been filed, name and address of carrier

Name   Address

EMPLOYEE'S WEEKLY GROSS EARNINGS $

Date ____________ Signature ____________ Title ____________

Name (printed) of Company Official ____________ Company Phone Number ____________

SEE INSTRUCTIONS ON REVERSE SIDE OF THIS FORM

CLAIM FORM – DISTRICT NO.9, WELFARE TRUST Weekly Benefits Only

INSTRUCTIONS

IN ORDER TO PROCESS YOUR CLAIM FOR WEEKLY BENEFITS UNDER DISTRICT NO. 9, I. A. OF M. & A. W. WELFARE PLAN IT WILL BE NECESSARY THAT YOU FOLLOW THESE INSTRUCTIONS EXACTLY.

WHEN TO FILE: This form is to be used to file for weekly benefits only. Complete the form as soon as your absence from work due to a disability exceeds the waiting period.

HOW TO FILE: You must complete all information under Section I as the insured employee. Failure to complete each item might delay payment of your claim.

Your Doctor must complete Section II and indicate a date for your return to work.

Your employer must complete Section III. Be sure that the name of the company, the address and phone number is in the appropriate spaces.

WHERE TO FILE: After Section I, II, and III have been completed the form should be mailed to:

DISTRICT NO. 9, I. A. OF M. & A. W.
WELFARE FUND
12365 St. Charles Rock Road
Bridgeton, MO 63044

Completion and submission of this form does not entitle you to any benefits for which you are not eligible in accordance with the terms of the plan.

WEEKLY INCOME BENEFITS FOR ILLNESS OR ACCIDENTAL INJURY

A. Generally

In the event you suffer a loss of earnings due to an illness or injury which prevents you from performing your job, weekly benefits are payable up to the maximum shown in the Schedule of Benefits.

Weekly benefits begin (see chart), and continue for the maximum number of weeks set forth in the Schedule of Benefits during any one continuous period of disability.

	Accident Disability	Illness Disability
Core Plan	First Day of Disability	Eighth Day of Disability
D9A Plan	Eighth Day of Disability	Eighth Day of Disability

There is no reduction or restriction of benefits because of age.

Weekly Income Benefits do not require you to be house confined; however, you must be under the direct care of a physician.

No weekly income benefits are provided to dependents.

B. Continuous Period – New Period

For this coverage, a continuous period of disability includes all periods of disability due to the same or related cause or causes, separated by less than three months of continuous, full-time, active work.

C. Limitations

Coverage for Weekly Income Benefits is limited to the maximum number of weeks shown on the Schedule of Benefits *per calendar year*. Accordingly, if you have more than one illness or accidental injury during a calendar year that prevents you from working, all Weekly Income Benefits added together cannot exceed the maximum number of weeks shown on the Schedule of Benefits.

D. No Weekly Income Benefit for Work-Related Illness or Injury

The Plan will not pay you weekly income benefits if your illness or injury arises out of or in the course of any employment for any employer or any self-employment or for which the individual is entitled to benefits under any workmen's compensation or occupational disease law or for which the individual receives any settlement from a worker's compensation carrier or self-insured employer.

Once you allege an injury is work-related, the Plan will not pay weekly income benefits until:

1. an Administrative Law Judge (ALJ) determines the injury is not work-related, or
2. until the worker's compensation claim is dismissed and the Plan receives medical evidence that the injury is not work-related.

E. Other Exclusion

No weekly income benefits are payable for any injury or illness that results from or is due to any war or act of war, whether declared or undeclared.

No benefits are payable for any illness or injury that occurs during or as a result of your engaging in conduct that constitutes a crime, as determined by the Plan and the Trustees.

F. Guidelines Applied

The Plan applies the guidelines in the "Official Disability Guidelines Treatment in Workers' Comp" (ODG Treatment in Workers' Comp) published by the Work Loss Data Institute in determining weekly income benefits provided under this Section 7.