# HOW TO FILE A CLAIM FOR WEEKLY DISABILITY BENEFITS

(Disability Claim Form is Attached)

A fully completed and signed Disability form (both sides) must be sent in from you and the physician who originally took you off work due to your illness or injury. The Disability form must be received in this office within one year from the date your disability begins.

If the disability is caused from any type of accident, you must give all the details of this accident (what, when, where, and how it occurred). In the case of a moving vehicle accident, a copy of the Police Report needs to be submitted to our office.

**Please note that a Chiropractor (DC), Nurse Practitioner (APN, FNP-C, NP), or Physician's Assistant (PA, PA-C) cannot certify your disability.**

**You must be under the regular medical care of a Physician (MD/DO/DPM) throughout the disability period.** This means you will need to follow-up with your physician every four to six weeks to verify your disability status and progress of your treatment. We will send requests directly to your physician for any additional information we require to continue your Disability Benefits. However, if your physician fails to reply promptly, then your benefits may be delayed.

**INSTRUCTIONS:** The member should complete the Members' side of the form in its entirety and sign and date the form at the bottom. After the member has been disabled the minimum of eight (8) days; then the member should present the form to the Physician to complete and sign the Physician's side of the form. The **ORIGINAL Disability claim form** with the hand signatures must be submitted to our office to file the claim. **Faxed, scanned, or emailed copies of Disability applications are not acceptable to receive benefits.**

**If you are receiving Workers' Compensation Benefits from your employer**; you must also submit copies of your check stubs on an ongoing basis until released to work or until the Maximum of 17 weeks has been credited. We will require these copies to verify your continued Disability and to issue the Disability Credits to your Marketplace Credit Bank.

If your Workers' Compensation claim was denied, then you should submit a copy of the Denial Letter, when received. You may also contact our office for further instructions on applying for the Weekly Disability payments under a Subrogation Agreement.

**VERY IMPORTANT:** Once you have been released by your doctor or have returned to work, we will need a copy of your doctor's signed authorization to go back to work. You can fax a copy to the Disability Dept. at **(708) 352-3310.** You can also email the copy as well. You may contact the Disability Department for the email address. If an overpayment has occurred, we will contact you as soon as possible to make arrangements for re-payment.

(OVER)

# SCHEDULE OF WEEKLY DISABILITY BENEFITS

## Weekly Benefit Amount - $400.00

As an Active Eligible Employee, you may receive a **weekly disability benefit** if you are unable to work for more than eight (8) consecutive days because of an injury or illness and you are under the regular care of a medical doctor (M.D./D.O./D.P.M.). If you meet the 8-consecutive day requirement, your benefit begins retroactively to day one.

A partial week of disability is paid at a daily rate equal to the weekly amount divided by 7 days. You may receive this benefit for up to 52 weeks for each disability period. Municipal employee benefits are payable up to 30 days per disability period.

**ELIGIBILITY CREDITS**: For the first 17 weeks of a disability, you receive credit into your Marketplace Credit Bank for each business day of disability based on your Health Plan Option and Coverage Tier. This benefit covers both an occupational and a non-occupational illness or injury. Municipal employees do not receive this benefit.

**WEEKLY BENEFIT:** If your disability is related to a non-occupational illness or injury, you are entitled to receive a weekly benefit less any amounts you receive from a wage continuation program through your employer, group insurance plan, or government plan.

After the commencement of weekly disability benefits, you must provide the Fund Office with medical certification or your illness or injury period from a legally qualified physician (M.D./D.O./D.P.M.) on a continuing basis. You may be required to be examined by a doctor specified by the Fund's Administrative Manager at any time during the disability period.

By law this benefit is subject to federal income taxes and the Fund will withhold applicable Social Security (FICA) taxes. If you receive a weekly disability benefit from the Fund, then you will be issued a W-2 verifying your Earnings.

## Please note that No benefits shall be payable for any:

- disability that begins while an employee is not actively working for a contributing employer;
- disability for which the employee is not under the care of a doctor (M.D./D.O./D.P.M.);
- period of time for which the Physician has not certified the employee's TOTAL Disability;
- period of time for which you received disability pension benefits;
- disability resulting from a loss, problem, complaint, pain or ailment which did not arise from an objectively determined and documented medical impairment;
- period of time for which you are receiving unemployment benefits through a state unemployment insurance program.
- Disability claims received after one-year from the date the Disability begins.

**MIDWEST OPERATING ENGINEERS WELFARE FUND**

**6150 Joliet Road, Countryside, Illinois 60525-3994 Fax (708) 352-3310 Telephone (708) 937-0327**

# MEMBER'S DISABILITY BENEFITS APPLICATION

MEMBER'S FULL NAME_____ MEDICAL ID NUMBER _____

HOME ADDRESS _____
Street City State Zip Code

PHONE (____)_____ DATE OF BIRTH _____ SEX ___M ___F MARTIAL STATUS ___M ___S

LAST DAY WORKED _____ JOB SITE _____

WHAT EQUIPMENT DID YOU OPERATE _____

EMPLOYER'S NAME _____

**ORIGINAL HAND SIGNED FORM NEEDS SUBMITTED FOR BENEFITS**

EMPLOYER'S ADDRESS _____
Street City State Zip Code

DATE INJURY OCURRED OR ILLNESS BEGAN _____ DATE FIRST TREATED_____ FIRST FULL DAY UNABLE TO WORK DUE TO CONDITION _____

PLACE OF FIRST TREATMENT _____

REASON FOR TREATMENT _____

IF INJURY, WHERE DID IT OCCUR _____

HOW DID IT OCCUR _____

WAS INJURY OR SICKNESS CAUSED BY YOUR EMPLOYMENT? YES _____ NO _____

HAVE YOU FILED WITH WORKER'S COMPENSATION? YES _____ NO _____

DO YOU HAVE ANY OTHER GROUP HEALTH COVERAGE? YES _____ NO _____ If yes, provide:

Name of Your Other Group Insurance Company Claim # or Policy #

Full Address Telephone

I hereby certify the statements hereon and attached are complete and accurate, and I authorize any person or institution rendering care, or any person or organization in possession of insurance or other benefit information concerning me to furnish or disclose all known facts concerning this disability. A copy of this authorization shall be as valid as the original.

**MEMBER'S SIGNATURE** _____ **DATE** _____

# PHYSICIAN'S DISABILITY STATEMENT

Completed by Physician's office Only - Please complete ALL applicable areas

PATIENT'S FULL NAME_____ MED ID NUMBER_____

PATIENT'S AGE_____ HEIGHT_____ WEIGHT_____ ICD CODES_____

**DIAGNOSIS** _____

DESCRIBE ANY OTHER INFIRMITY AFFECTING PRESENT CONDITION_____

DATE INJURY/ILLNESS HAPPENED OR SYMPTOMS FIRST APPEARED _____ DATE FIRST CONSULTED YOU FOR THIS CONDITION_____

**LIST ALL DATES OF TREATMENT, OFFICE VISITS** _____

_____

_____ **NEXT APPOINTMENT**_____

IF INPATIENT, DATE ADMITTED _____ DATE DISCHARGED _____

HOSPITAL/FACILITY NAME_____

IF SURGERY WAS PERFORMED, GIVE DATE _____ AND LIST SURGICAL PROCEDURE(S)

_____

_____

**COURSE OF TREATMENT / MEDICATIONS**_____

_____

_____

WAS INJURY OR SICKNESS CAUSED BY THE PATIENT'S EMPLOYMENT? YES _____ NO _____

If yes, explain _____

**DATE YOU DETERMINED PATIENT DISABLED** _____ RETURN TO WORK DATE - ESTIMATED_____ OR ACTUAL_____

DATE ABLE TO RETURN TO WORK WITH RESTRICTIONS _____

If Restricted Duty, please list Restrictions _____

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**PHYSICIAN'S NAME** (please print) Degree(s) **Phone#** **Fax#**

**ADDRESS**_____

Street Suite# City State Zip Code

**PHYSICIAN'S SIGNATURE** _____ **DATE** _____

**(M.D./D.O. ONLY)**

**We DO NOT accept a Signature Stamp or Someone Else (NP-C, PA-C) Signing for the Physician as certification of a patient's disability.**