DISABILITY INCOME BENEFITS
CLAIM FORM

(Return Both Copies to the Fund Office)

Iron Workers' Local 15 & 424
321 Research Parkway, Suite 210
Meriden, CT 06450
Telephone (203) 238-1204
Toll-Free Number 1-800-982-3709

ALL QUESTIONS MUST BE COMPLETED BY MEMBER IN ORDER TO APPLY FOR DISABILITY INCOME BENEFITS

MEMBER'S NAME, ADDRESS AND PHONE NO. IS THIS A NEW ADDRESS? ❑Yes ❑No	SOCIAL SECURITY NUMBER	DATE OF BIRTH	LOCAL UNION
	MARITAL STATUS: ❑SINGLE ❑MARRIED ❑SEPARATED ❑DIVORCED ❑WIDOWED		

PLEASE PROVIDE THE FOLLOWING INFORMATION AS IT RELATES TO THIS DISABILITY.

Type of illness or injury _____ Was this due to an injury or accident? ❑Yes ❑No
If Yes, please answer the following questions: Date of accident or injury: _____ Time: _____ ❑a.m. ❑p.m.
Where? ❑at home ❑on job ❑other If Other, explain where: _____
How did accident or injury happen: _____
Will a liability claim in connection with these charges be filed with any insurance carrier or against any individual or legal entity either through civil suit or any other means? ❑Yes ❑No If Yes, on the reverse side of this form, please provide the names and addresses of your attorney, the other party involved, and the insurance carrier.
Date last worked: _____ Number of hours worked on that date: _____
Have you returned to work? ❑Yes ❑No If Yes, date you returned to work: _____
Did you collect Unemployment or Workers' Compensation Benefits during this period? ❑Yes ❑No
If YES, please provide a statement from Unemployment or Workers' Compensation indicating the dates you received benefits.
The Fund is required to offer a Member the option to have Income Tax Withholdings made from Weekly Disability Benefits if requested. This election may be changed at any time. Please check one of the following boxes:

❑ Do not withhold taxes ❑ Withhold Taxes – Forms attached

TO ALL PHYSICIANS AND OTHER HEALTH PROFESSIONALS, AND ALL HOSPITALS AND OTHER HEALTH CARE INSTITUTIONS: You are authorized to provide the Extended Benefit Fund, Aetna Life and Casualty and any independent claim administrators and consulting health professionals and utilization review organizations with whom the Extended Benefit Fund or Aetna has contracted, information concerning health care, advice, treatment or supplies provided the Patient (including that relating to mental illness). This information will be used for the purpose of evaluating and administering claims for benefits. This authorization is valid for the term of coverage of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original. **The statements contained within this claim form are true to the best of my knowledge and belief. I understand I am responsible for charges not covered by this Plan.**

Member's Signature _____ **Date** _____

TO BE COMPLETED BY PHYSICIAN

PATIENT'S NAME	DATES OF TOTAL DISABILITY FROM THROUGH	DATE PATIENT ABLE TO RETURN TO WORK
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE. **1.** **2.** **3.**		IS CONDITION DUE TO A WORK-RELATED INJURY OR DISEASE? YES NO 1 ❑ ❑ 2 ❑ ❑ 3 ❑ ❑

PROCEDURES, MEDICAL SERVICES, SUPPLIES FURNISHED

Date of Service	Place of* Service	Procedure Code ** (Identify)	Description of Service	Type of Service*** Charges	Diagnosis Code††

NAME OF PHYSICIAN OR SUPPLIER	Enter the taxpayer identifying number to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number.	
ADDRESS ❑CHECK IF NEW	TELEPHONE NO.	Physician's or Supplier's Signature Date / PATIENT'S ACCOUNT NO.

*PLACE OF SERVICE CODES

1 - (H) - Inpatient Hospital
2 - (OH) - Outpatient Hospital
3 - (O) - Doctor's Office
4 - (H) - Patient's Home
5 - - Day Care Facility (PSY)
6 - Night Care Facility (PSY)
7 - (NH) - Nursing Home
8 - (SNF) - Skilled Nursing Facility
9 - - Ambulance
0 - (OL) - Other Locations
A - (IL) - Independent Laboratory
B - - Other Medical Surgical Facility
C - (RTC) - Residential Treatment Center
D - (STF) - Specialized Treatment Facility

***TYPE OF SERVICE CODES

1 - Medical Care
2 - Surgery
3 - Consultation
4 - Diagnostic X-Ray
5 - Diagnostic Laboratory
6 - Radiation Therapy
7 - Anesthesia
8 - Assistance at Surgery
9 - Other Medical Service
0 - Blood or Packed Red Cells
A - Used DME
M - Alternate Payment for Maintenance Dialysis
Y - Second Opinion on Elective Surgery
Z - Third Opinion on Elective Surgery

**PLEASE USE CURRENT PROCEDURAL TERMINOLOGY CODES FOR SURGERY

††PLEASE USE ICD ● 9 ● CM FOR DISCHARGE DIAGNOSIS