— Disability —

FOX VALLEY LABORERS HEALTH AND WELFARE FUND

2371 BOWES ROAD, SUITE 500, ELGIN, ILLINOIS 60123-5523
PHONE: (847) 742-0900
FAX: (847) 742-4430

*****INCOMPLETE FORMS WILL BE RETURNED TO MEMBER*****

— CLAIMANT'S REPORT —

PATIENT & MEMBER INFORMATION (To be completed by Member) **(PLEASE TYPE OR PRINT)**

MEMBER NAME (First, Middle Initial, Last)	MEMBER'S S.S. NO.	IF AN ACCIDENT PROVIDE: AM ❑ DATE _____ TIME _____ PM ❑ DESCRIBE IN DETAIL HOW AND WHERE:
MEMBER ADDRESS: (Street, City, State, Zip Code) TELEPHONE NO. (_____) _____	DATE OF BIRTH: (Month, Day, Year) WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT? Yes ❑ No ❑ B. AN ACCIDENT? Yes ❑ No ❑	

PLAN MEMBER PLEASE READ AND SIGN ON REVERSE SIDE

ATTENDING PHYSICIAN'S STATEMENT *****NOTES AND MEDICAL RECORDS MUST BE ATTACHED*****

DATE:	ILLNESS (FIRST SYMPTOM) or INJURY (ACCIDENT) or PREGNANCY (LMP)	DATE FIRST CONSULTED PHYSICIAN FOR THIS CONDITION	HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES / NO	IF AN EMERGENCY, CHECK HERE
DATES OF TOTAL DISABILITY FROM	TO	DATE LAST WORKED	WAS SURGERY PERFORMED? DATE	
ON WHAT DATE WAS PATIENT OR WILL PATIENT, BE AVAILABLE FOR WORK?			FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED | DISCHARGED	
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY				

REMARKS

PHYSICIAN'S SIGNATURE	**TAX I.D. #**	PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS ZIP CODE & TELEPHONE NO.
DATE		

FOX VALLEY LABORERS HEALTH AND WELFARE FUND OF ILLINOIS

INSTRUCTIONS TO PLAN MEMBER

You must sign a separate authorization for release of information before we can process claims for you. No payment can be made until you have returned this signed authorization.

AUTHORIZATION FOR RELEASE OF INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, Veterans Administration Hospital, clinic, other medical or medically related facility, insurance company, consumer reporting agency, employer, union or group policyholder having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, my spouse or my minor children and any other non-medical information of me, my spouse or my minor children to give to the Trust shown on this letterhead (hereinafter call the Plan) or its legal representative, any and all such information.

I UNDERSTAND the information obtained by use of the Authorization will be used by the Plan, its Trustees or its authorized claims paying administrator to determine eligibility for benefits or services under the Plan. Any information obtained will not be released by the Plan to any person or organization EXCEPT as specifically provided in the next paragraph or to reinsuring companies, the Medical Information Bureau, Inc., group policyholder, contract holder or other persons or organizations performing direct administrative, professional, medical or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

I AUTHORIZE the Plan, the Trustees or the Plan's authorized claims paying administrator to release to anyone any information, with respect to me, my spouse or my minor children, which the Plan deems necessary because of the Coordination of Benefits provision contained in the Rules and Regulations of the Plan.

I UNDERSTAND that I may request to receive a copy of this Authorization.

I AGREE this Authorization shall be valid for the duration of my coverage under this Plan or through the third calendar year from the date shown below whichever is later.

Signed this _____ of _____, 20_____
DAY MONTH YEAR

Plan Member's Social Security Number _____

_____
PRINT NAME OF PLAN MEMBER

_____
SIGNATURE OF PLAN MEMBER

NOTE TO DOCTOR OR PROVIDER: If claim is submitted on a form other than the Fox Valley Laborers Health and Welfare Fund of Illinois claim form, this authorization must be attached to the claim form and given to the patient or sent to the Trust. If you wish, you may copy the authorization.