FOX VALLEY & VICINITY LABORERS

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Fox Valley Laborers Health and Welfare Fund
Loss of Time Claim Form

2371 Bowes Road, Suite 500; Elgin, IL 60123-5523

SECTION 1: TO BE COMPLETED BY THE PARTICIPANT (*please print clearly*)

Please complete both sides of the claim form.
Incomplete forms will be returned and may delay consideration of your claim for payment.

FVL ID or Social Security Number: _____

First Name: _____ Last Name: _____

Street Address: _____

City, State, Zip: _____

Phone Number: _____ Date of Birth: _____ Local: _____

_____

DETAILS OF YOUR DISABILITY

Describe your injury / illness: _____

_____

_____

Date injury occurred or illness began: _____ Date first treated: _____

First full day unable to work due to condition: _____

If injury, where did it occur: _____

How did it occur: _____

_____

YES	NO	
☐	☐	1. Is this injury or illness due to an accident?
☐	☐	2. Is there a third party involved responsible for the accident?
☐	☐	3. Were you under the influence of alcohol or an illegal substance?
☐	☐	4. Was injury or illness caused by your employment?
☐	☐	5. Have you filed or do you intend to file a claim under Workers' Compensation?

PLEASE READ AND SIGN SECTION 3 ON THE REVERSE SIDE
(No payment can be made until you have returned the signed Authorization)

SECTION 2: TO BE COMPLETED BY THE PHYSICIAN (*please print clearly*)

Notes / medical records must be attached. Fax or email claim form and notes / medical records to the Fox Valley Laborers Office.

Patient's Name: _____ Date of Birth: _____

ATTENDING PHYSICIAN'S STATEMENT

Diagnosis or nature of illness or injury: _____

_____

First date of treatment for this injury or illness: _____

Was condition related to an accident: YES / NO Was condition related to patient's employment: YES / NO

Was surgery performed? YES / NO Dates of hospitalization: _____

Dates of total disability: From: _____ To: _____

On what date was patient or will patient be available for work: _____

Physician's Name: _____ Tax ID Number: _____

Physician's Address and Phone Number: _____

_____

_____

I UNDERSTAND it is fraudulent to complete this form with information known to be false or to knowingly omit important facts, and that criminal and/or civil penalties can result from such an act.

Physician (M.D / D.O. only) Signature: _____ Date: _____

SECTION 3: TO BE COMPLETED BY THE PARTICIPANT

AUTHORIZATION FOR RELEASE OF INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, 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 to the Fox Valley Laborers Health and Welfare Fund (hereinafter "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 the Loss of Time Benefit under the Plan. I AGREE this Authorization shall be valid for the duration of my eligibility under this Plan or through the third calendar year from the date shown below, whichever is later. I UNDERSTAND that I may request a copy of this Authorization.

I UNDERSTAND it is fraudulent to complete this form with information known to be false or to knowingly omit important facts, and that criminal and/or civil penalties can result from such an act. I ACKNOWLEDGE that if I am approved for a Loss of Time Benefit, an updated claim form must be submitted to the Fund Office every four weeks to continue the benefit under the terms of the Plan. I UNDERSTAND that it is my responsibility to notify the Fund Office upon physician's release to return to work. I UNDERSTAND that I am obligated to repay the Fox Valley Laborers Health and Welfare Fund for any overpayment of benefits that may occur.

_____

Participant Name (*please print clearly*)

_____ _____

Participant Signature Date