Construction Industry Laborers Fringe Benefit Funds

INITIAL REPORT OF CLAIMS

Reset Form

NO BENEFITS CAN BE PAID UNLESS THIS FORM IS COMPLETED IN ITS ENTIRETY

INSTRUCTIONS:

This form is to be completed by the member. Complete member's section fully. Be sure to include your Social Security Number and sign member's signature section. Remember to attach itemized bills.

RETURN COMPLETED FORM TO:

Construction Industry Laborers Welfare Fund
PO Box 909500
Kansas City, MO 64190-9500
(816) 777-2669 | Fax: (816) 756-3659

MEMBER COMPLETES THIS SECTION:

Name of Member		Home Phone
Date of Birth	Social Security Number	Occupation
Employer		
Home Address	City	State / Zip Code

If claims is for member's disability, show date last worked: Date resumed work:

COMPLETE THIS SECTION IF CLAIM IS FOR DEPENDENT:

Name of Dependent	Relationship to Member	Date of Birth

Is Dependent Employed?
☐ YES ☐ NO If yes, state name of Employer

Is the Patient Covered by Any Other Insurance, Prepaid Health Plan, Medicare or Other Governmental Plan?
☐ YES ☐ NO

Insured's Name

Group Insurance Company or Plan's Name

Policy Number

Group Insurance Company or Plan's Address	City	State	Zip Code

Name of Spouse	Spouse's Date of Birth	Spouse's Social Security Number

COMPLETE THIS SECTION FOR ALL CLAIMS:

Nature of Sickness or Injury:	Date Accident Occurred or Sickness Began:	Date First Treated:
If Hospitalized, Name of Hospital:	Date Admitted:	Date Discharged:

Did someone intentionally cause this injury? ☐ YES ☐ NO

Was injury due to an accident? ☐ YES ☐ NO

Did the accident happen on your property? ☐ YES ☐ NO If no, address where accident occurred:

Was this due to an auto accident? ☐ YES ☐ NO

Did injury or illness occur in the course of employment? ☐ YES ☐ NO

Have you filed this claim under Workmen's Compensation? ☐ YES ☐ NO

Have you started a lawsuit related in any way to this injury/illness? ☐ YES ☐ NO

Have you received any settlement, payment, recovery of benefits, including insurance company policy, related in any way to this injury/illness? ☐ YES ☐ NO

Are you an owner or officer of your employer? ☐ YES ☐ NO

Are you receiving accident/sick pay from your employer? ☐ YES ☐ NO

Have you hired an attorney to represent you regarding this claim? ☐ YES ☐ NO

I hereby make claim for benefits and certify that the above statements are true and correct to the best of my knowledge and belief. I authorize the above named institution or physician to release information concerning my enrollment, related records and medical records to the Construction Industry Laborers Welfare Fund.

Insured Member's Signature _____ Date _____

INSTRUCTIONS:

ATTENDING PHYSICIAN'S STATEMENT

This form does not have to be completed, **if** you can furnish the Administrator with a complete itemized and coded statement of services from the doctor. If you do not have a complete itemized and coded statement, your physician may use this form to report his/her services and charges.

DISABILITY

To collect disability benefits, your physician must complete questions, 1, 2, 4, 5, 7, 8, 9 and sign and date this form. If you are unable to work due to a work related disability that occurred while you were working in the jurisdiction of Construction Industry Laborers Welfare Fund, you must submit evidence (such as check stubs) that you are receiving weekly disability benefits from Worker's Compensation. You will be credited with 30 disability hours for each full week of disability.

ATTENDING PHYSICIAN'S STATEMENT:

1. Diagnosis and concurrent conditions (if diagnosis code other than ICDA used, give name).

2. Is the condition due to injury or sickness arising out of patient's employment?	Is condition due to pregnancy? If yes, approximate date pregnancy commenced. ☐ YES ☐ NO

3. Report of services (or attach itemized bill. If previous form submitted to this carrier, you need show only dates and services since last report).

Date of Services	Place of Services	Description of Surgical or Medical Services Rendered	Procedure code - If used If code other than CPT used, give name	Charges	**Office Use Only**

+O = Doctor's Office IH = Inpatient Hospital
H = Patient's Home OH = Outpatient Hospital
NH = Nursing Home OL = Other Location
ICDA = International Classification of Diseases
CPT = Current Procedure Terminology (current location)

Total Charges $_____
Amount Paid $_____
Balance Due $_____

4. Date symptoms first appeared or accident happened.	5. Date patient first consulted you for this condition.	6. Has patient ever had same or similar condition? if yes, when and describe. ☐ YES ☐ NO
7. Is patient still under your care for this condition? ☐ YES ☐ NO	8. Patient was continuously totally disabled (unable to work). From: Thru:	9. Date patient should be able to return to work, if still disabled.
10. Does patient have other heath coverage? If yes, please identify ☐ YES ☐ NO		Taxpayers identification number:

Print Physician's Name	Physician's Signature	Degree	Date
Street address		Telephone	
City	Providence	State	Zip Code

MEMBERS ASSIGNMENT (PLEASE READ BEFORE SIGNING)

To be completed and signed by the Member if direct payment by fund to surgeon or physician is desired. (This assignment may not be honored if signed by a dependent or person other than the Insured Member).

I hereby authorize the Construction Industry Laborers Welfare Fund to pay directly to the above named hospital or physician the Medical or Surgical Expense Benefits to which I am entitled under the terms of the Group Policy.

Insured Member's Signature _____ Date _____