RETURN THIS FORM TO:

CENTRAL LABORERS' WELFARE FUND

P.O. BOX 1267 – JACKSONVILLE, ILLINOIS 62651-1267
PHONE-1-800-252-6571○ FAX-1-217-243-8619

STATEMENT OF CLAIM FOR LOSS OF TIME BENEFITS

This report should be completed immediately.

Instructions: The Employee/Participant must complete Parts 1 and 3. Part 2 includes important information regarding potential pension benefits that participants in the Central Laborers' Pension Fund may be eligible to receive. The Employee's/Participant's physician must complete Part 4. **No Benefits can be paid until this entire form is completed and returned to the Welfare Fund**.

PART 1 – EMPLOYEE COMPLETES IN ALL CASES

Employee's Name (Print)__________________________ Social Security No.__________________

Address:____

(Number) (Street) (City) (State) (Zip Code)

Date of Birth:______________ Sex________ Telephone Number:________________ Local Union #__________

Is your disability due to accident or sickness? State which:__________________________________

Was the disability a result of your employment? Yes______ No______

On what date did you cease working? Date____________________ at ______________ (hour) am ____ pm ____

For whom were you working at the time you became disabled? ______________________________

On what date did you, or do you expect to resume full/part time work?

Date:____________________ Duties resumed ______________________________________

IF AN ACCIDENT WAS INVOLVED, ANSWER THE FOLLOWING:

When did the accident happen? Date____________________ at ______________(hour) am ____ pm ____

Were you performing the duties of your occupation when the accident happened? Yes______ No______

Give a brief description of the accident:____

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Part 2 - NOTICE TO PARTICIPANTS IN THE CENTRAL LABORERS' PENSION FUND

If you are a **participant** in the **Central Laborers' Pension Fund**, you may be entitled to receive Pension Credit and/or Vesting Service for periods you are unable to work in Covered Employment because of a disability. To permit the Welfare Fund to share medical claims information with the Pension Fund regarding your disability, you must also sign an **Authorization for the Release Medical Records – Loss of Time & Non-Work Disability Credit Benefit**. The form is at www.central-laborers.com/forms/html or by calling 1-800-252-6571.

PART 3 – COMPLETE IN ALL CASES

I hereby certify the statements hereon and attached are complete and accurate and I authorize any physician, medical practitioner, hospital, clinic, or other medical or medically related facility, government agency, insurance company or employer to disclose any knowledge or information which is material to the processing of this claim to The Central Laborers' Welfare Fund, P. 0. Box 1267, Jacksonville, Illinois 62651. A photocopy of this authorization shall be considered as effective and valid as the original.

Date:____________________ Employee's Signature ______________________________________

PART 4 – ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

Patient's Name____

Diagnosis and Concurrent Conditions ____

____

Did the illness or injury arise out of the patient's employment? Yes______No______

Date of First Treatment ___________________________

Date of Most Recent Treatment ___________________________

Frequency of Treatments ___________________________

The patient has been Continuously Disabled (Unable to Work) from _______________ through _______________

Date Total Disability Terminated ___________________________

If still Disabled, when should the Patient be able to return to work? ________________________________

Remarks/Comments:

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________________________________ ____________________

Signature Type of Degree

Date:____________________________

____

Street Address

____

City, State, Zip Code

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Questions?

If you have any questions regarding this form or Loss of Time benefits, please contact 1-800-252-6571.