



DISABILITY CLAIM FORM

INSTRUCTIONS FOR COMPLETING THE CLAIM FORM

- Part A must be completed by the employee.
- Part B must be completed by your physician.
- Return the completed form to the address shown above.



**Northern Illinois Laborers'
Health & Welfare Fund - 070613**

**Send all claims to:
Professional Benefit
Administrators, Inc.**
P. O. Box 4687
Oak Brook, IL 60522-4687
630-655-3755
Fax: 630-655-8993

Part A - Employee Information

Employee name:	Date of birth:	Social Security #:
Home Address:		Phone:
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed	
Claim is for: <input type="checkbox"/> Sickness / Condition: Briefly explain:		
Please List Symptoms:		
<input type="checkbox"/> Accident: Date/Time:		Location:
Explain What Happened:		
Did sickness or injury arise out of or in the course of any employment? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please explain including employers name:		
Did you lose time from work because of disability? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, give date last worked before becoming totally disabled: <input type="checkbox"/> AM <input type="checkbox"/> PM		
Date you returned to work: _____ or when you expect to return to work: _____		
<p>CERTIFICATION & AUTHORIZATION TO RELEASE INFORMATION: I certify that these statements and answers are true to the best of my knowledge and belief. I hereby agree to reimburse this plan to the extent that benefits are provided under any Workers' Compensation Law, similar legislation, and/or any settlements related to such coverages.</p> <p>I hereby authorize any insurance company, provider, or any other organization to release all information to PBA, Inc., which may have a bearing on the benefits payable under this plan. A photocopy of this authorization will be considered as effective and valid as the original, and will be valid for one year from the date below.</p>		
Date: _____	Signature of Employee: _____	

Part B – Attending Physician Statement

Date of Illness (First Symptom) OR Injury (Accident) OR Pregnancy (LMP):	Date first consulted for this condition:	Most Current Date of Treatment:
Date of short term disability:	Date released to light duty or part time:	Date patient able to return to work:
From: _____ To: _____	From: _____ To: _____	
Diagnosis of sickness or injury (describe complications, if any):		For services related to hospitalization give hospitalization dates:
Date of services:		From: _____ To: _____
		Next scheduled date of treatment:
Is patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, give discharge date:		
Is patient able to perform work of any kind? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe:		
Date: _____	Physicians Name (please print) _____ Degree _____	Individual Practitioner's SS#: _____
Physician Signature _____ Phone _____		Other Employer ID #'s: (must be furnished under authority of law)
Street Address _____	City or Town _____	State or Province _____ Zip Code _____