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: 630-286-4611
E-mail: stddepartment@pbaclaims.com

Part A - Employee Information

Employee name:	Date of birth:	Social Security #:
Home Address:		Phone:

Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

Claim is for: ☐ Sickness / Condition: Briefly explain:

Please List Symptoms:

☐ Accident: Date/Time: Location:

Explain What Happened:

Did sickness or injury arise out of or in the course of any employment? ☐ Yes ☐ No

If yes, please explain including employers name:

Did you lose time from work because of disability? ☐ Yes ☐ No

If yes, give date last worked before becoming totally disabled: ☐ AM ☐ PM

Date you returned to work: or when you expect to return to work:

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.

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.

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: From: To:	Date released to light duty or part time: * From: To:	Date patient able to return to work:

Is patient able to perform laborers' work? ☐ Yes ☐ No If yes, please describe:

Diagnosis of sickness or injury (describe complications, if any):	For services related to hospitalization give hospitalization dates: From: To:
Date of services:	Next scheduled date of treatment:

Is patient still under your care for this condition? ☐ Yes ☐ No If no, give discharge date:

Is patient able to perform work of any kind? ☐ Yes ☐ No If yes, describe:

Date: Physicians Name (please print) Degree	Individual Practitioner's SS#: Other Employer ID #'s: (must be furnished under authority of law)

Physician Signature Phone

Street Address City or Town State or Province Zip Code