



United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund

1300 Higgins Road, Suite 300 ♦ Park Ridge, IL 60068-5713 ♦ 847-384-7000 ♦ 800-621-5133

CLAIMS OFFICE FAX 847-384-0196 ♦ TDD 847-384-0199 ♦ www.ufcwmidwest.org

Statement of Claim — For Hospital, Surgical, Medical and/or Income Protection Benefits

Attach bill(s), complete the front—complete reverse if salary loss is involved—and return to above address.

Employee-Member and Claim Information—Receipt of this claim form does not guarantee payment of benefits					
1. YOUR FULL NAME (EMPLOYEE-MEMBER)		MAIDEN NAME	SOCIAL SECURITY NUMBER		
2. STREET ADDRESS		CITY	STATE	ZIP	CHECK <input checked="" type="checkbox"/> IF NEW ADDRESS <input type="checkbox"/>
3. DAYTIME (AREA CODE) PHONE NUMBER	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	<input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED	<input type="checkbox"/> WIDOWED DATE MARRIED
4. NAME AND ADDRESS OF ANY NON-UFCW COMPANY WHERE YOU ARE ALSO EMPLOYED					
5. DESCRIPTION OF SICKNESS OR INJURY, INCLUDING FULL DESCRIPTION OF WHERE AND HOW INJURY HAPPENED—FAILURE TO SUPPLY ALL REQUESTED INFORMATION WILL DELAY PROCESSING OF YOUR CLAIM:					
6. NAME AND ADDRESS OF PHYSICIAN WHO FIRST TREATED THIS CONDITION					DATE FIRST TREATED
7. DATE AND TIME OF INJURY OR BEGINNING OF SICKNESS <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	IF YOU STOPPED WORK, GIVE DATE	IF RETURNED TO WORK, GIVE DATE	CHECK <input checked="" type="checkbox"/> IF SICKNESS OR INJURY IS DUE TO THE PATIENT'S EMPLOYMENT (ON-THE-JOB) <input type="checkbox"/>	CHECK <input checked="" type="checkbox"/> IF A WORKER'S COMPENSATION CLAIM HAS OR WILL BE FILED <input type="checkbox"/>	
Spouse (or other Parent if claim is for Dependent Child) Information—Complete for all Claims					
8. FULL NAME OF SPOUSE OR PARENT		RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER	
9. IF DIFFERENT FROM EMPLOYEE-MEMBER, STREET ADDRESS		CITY	STATE	ZIP	DAYTIME (AREA CODE) PHONE NUMBER
10. NAME AND ADDRESS OF SPOUSE OR PARENT'S EMPLOYER (OR FORMER EMPLOYER)				(AREA CODE) PHONE NUMBER	
11. IS PATIENT COVERED UNDER ANY OTHER GROUP HEALTH INSURANCE OR BENEFIT PLAN WHICH MAY ALSO PAY ANY MEDICAL EXPENSES ON THIS CLAIM (SUCH AS, GROUP BLUE CROSS, A SCHOOL PLAN, A GOVERNMENT PLAN, AUTO INSURANCE PLAN, ETC.)? IF "YES," PROVIDE THE INFORMATION REQUESTED BELOW REGARDING THE OTHER PLAN. <input type="checkbox"/> YES <input type="checkbox"/> NO					
12. NAME OF PLAN OR COMPANY				POLICY NUMBER	
13. ADDRESS		CITY	STATE	ZIP	(AREA CODE) PHONE NUMBER
Dependent Information—Complete Only if Claim is for a Dependent					
14. DEPENDENT'S FULL NAME—FIRST AND LAST NAME		RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER	
15. IF DIFFERENT FROM EMPLOYEE-MEMBER, STREET ADDRESS		CITY	STATE	ZIP	
16. EMPLOYER NAME AND ADDRESS					CHECK <input checked="" type="checkbox"/> IF NOT EMPLOYED <input type="checkbox"/>
17. IF CHILD, IS <input type="checkbox"/> YES CHILD MARRIED? <input type="checkbox"/> NO	IF CHILD OVER 18 YEARS, IS CHILD A FULL-TIME STUDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES," SUBMIT EVIDENCE OF STUDENT STATUS DURING THE SEMESTER WHEN EXPENSE WAS INCURRED (E.G., LETTER FROM SCHOOL)				
Signatures—Employee-Member and Patient (or Parent, if patient is a minor) must sign or benefits cannot be paid					
I certify that the above answers and statements, including any accompanying statements, are true and complete to the best of my knowledge and belief. I authorize any physician, medical examiner or practitioner, coroner, hospital, Veterans Administration Hospital, clinic, other medical or medical-related facility, insurance or reinsuring company, consumer reporting agency, employer, school, or group policyholder having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of the patient for whom claim is made, to give to United Food and Commercial Workers Unions and Employers Midwest Health Benefits Fund or its legal representative, any and all such information. A photocopy of this authorization shall be as valid as the original.					
Date _____	Signature _____		👉 Employee-Member sign here		
Date _____	Signature _____		👉 Patient (or Parent) sign here		
Assignment of Benefits: Authorization to Pay Benefits to Physician, Hospital or Other Provider—Sign only if benefits to be paid directly to provider					
I hereby authorize payment directly to the physician or other provider for any Surgical and/or Medical Benefits otherwise payable to me for services in connection with this claim.					
Date _____	Employee-Member Signature _____				

Statement of Claim — For Income Protection Benefits

A claim for Income Protection Benefits must be submitted immediately to the Benefits Fund Office. Subsequent **reports are required at least every three weeks** thereafter during the continuance of the disability. Failure to comply with these requirements will jeopardize your right to receive benefits. The Fund, at its own expense, has the right to have you examined by a doctor of its choice as often as it is necessary to establish total disability. If you do not submit to an examination requested by the Benefits Fund Office, benefits may not be paid.

To Be Completed by Disabled Employee-Member—Be sure you have signed on the front under "Signatures..."					
1. YOUR FULL NAME (EMPLOYEE-MEMBER)		SOCIAL SECURITY NUMBER	OCCUPATION		
Attending Physician's Statement for Disability Claim					
2. DIAGNOSIS AND CONCURRENT CONDITIONS (if Diagnosis Code other than ICDA used, please give name)					
3. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		IS CONDITION DUE TO PREGNANCY? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF "YES," APPROXIMATE DATE PREGNANCY COMMENCED	ESTIMATED DATE OF CONFINEMENT	
4. DATES OF SERVICE (If previous form submitted to this office, you need show only dates since last report)					
5. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO		PATIENT WAS CONTINUOUSLY TOTALLY DISABLED (unable to work) FROM _____ THRU _____		IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK	
6. DOES PATIENT HAVE OTHER HEALTH COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF "YES," PLEASE IDENTIFY _____			
7. PHYSICIAN'S NAME (PRINT)			DEGREE	(AREA CODE) PHONE NUMBER	
8. STREET ADDRESS		CITY	STATE	ZIP	
Date _____ Physician's Signature _____					
Employer's Statement—Employer must complete if Salary Loss is involved					
9. FIRST FULL DAY UNABLE TO WORK		DATE RESUMED WORK	DATE EXPECTED TO RESUME WORK	DATE AND TIME LAST WORKED	
10. BASIC GROSS WEEKLY EARNINGS		DATE TERMINATED	REASON FOR TERMINATION		
11. IF NOT PREVIOUSLY PROVIDED FOR THIS DISABILITY, INDICATE LAST 4 WEEKLY SALARIES PRIOR TO DATE STOPPED WORKING		WEEK #1	WEEK #2	WEEK #3	WEEK #4
12. PRIOR TO THIS DISABILITY, WAS THE EMPLOYEE <input type="checkbox"/> LAID OFF <input type="checkbox"/> ON LEAVE <input type="checkbox"/> RETIRED <input type="checkbox"/> DISCHARGED <input type="checkbox"/> QUIT					
13. IS THIS DISABILITY THE RESULT OF OCCUPATIONAL DISEASE OR INJURY ARISING IN THE COURSE OF EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			WILL A CLAIM BE MADE UNDER WORKER'S COMPENSATION? <input type="checkbox"/> YES <input type="checkbox"/> NO		
14. NUMBER OF FULL & PARTIAL SICK DAYS PAID		SICK DAYS PAID FROM _____ THRU _____		NUMBER OF SICK HOURS PAID	
15. (AREA CODE) PHONE NUMBER		VALIDATE WITH STORE STAMP			
Date _____ Authorized Signature—Employer _____					