



# AUTOMOBILE MECHANICS' LOCAL 701 WELFARE FUND

361 S. FRONTAGE ROAD, SUITE 100 | BURR RIDGE, IL 60527

TELEPHONE: (708) 482-0110 | TOLL FREE: (800) 704-6270 | FAX: (708) 482-9140

email: [701claim@mech701-benefits.org](mailto:701claim@mech701-benefits.org)

website: [www.mech701-benefits.org](http://www.mech701-benefits.org)

PLEASE CHECK IF YOUR ADDRESS HAS CHANGED SINCE YOUR LAST CLAIM

## CLAIM FOR SHORT-TERM DISABILITY BENEFITS

### PART I MEMBER'S STATEMENT (PLEASE PRINT)

Member's Name		Home Telephone Number ( )	Date of Birth / / ____ Male ____ Female	ID#/SS#
		Cell Phone Number ( )		
Home Address (Street, City, State, Zip)			Email Address: _____	
Current job title with your employer				
Briefly describe the daily duties of your job				
Date first treated for current condition / /		Name of Physician or Facility		
Is this Disability due to: _____ Motor Vehicle Accident _____ Other Accident/Injury _____ Sickness/Illness _____ Work-related Injury/Sickness _____ Pregnancy				
Please describe your medical condition(s) or injury that is resulting in your disability. When did the symptoms first appear? If related to an accident/injury, state <b>WHEN, WHERE</b> and <b>HOW</b> the injury occurred.				
Are you pursuing reimbursement from <b>ANY</b> other party or insurance carrier in relation to this condition? _____ Yes _____ No If yes, please provide the name, address and telephone number of the other party or insurance carrier.				
Have/will you receive any salary/vacation/sick pay for this period of disability: _____ Yes _____ No If yes, provide specific dates paid by your employer _____/_____/_____ through _____/_____/_____				
<b>IF YOUR CLAIM WAS DENIED BY THE WORKERS' COMPENSATION CARRIER &amp; COMMISSION FORWARD A COPY OF THE DENIAL LETTER(S) WITH YOUR CLAIM</b>				
I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct and complete. I will reimburse the fund for any over-payment made to me or in my behalf due to error or omission on this form.				
_____ SIGNATURE OF MEMBER OR LEGAL REPRESENTATIVE			_____ DATE	
_____ PRINTED NAME OF LEGAL PERSONAL REPRESENTATIVE			_____ RELATIONSHIP TO MEMBER	

**WHEN RELEASED TO RETURN TO WORK, PLEASE FAX A COPY OF THE PHYSICIAN'S RELEASE TO 708-482-9140**

**PART II ATTENDING PHYSICIAN'S STATEMENT (ALL QUESTIONS MUST BE ANSWERED TO AVOID DELAY)**

<b>H I S T O R Y</b>	Name of Patient (Last, First, M.I.)- Please Print _____		Date of Birth _____ / ____ / ____	
	Patient's symptoms result from (check all that apply): _____ Employment    _____ Illness    _____ Auto Accident    _____ Other Accident    _____ Pregnancy			Type of delivery _____
	Date Symptoms first appeared _____ / ____ / ____		Expected/Actual Date of Delivery _____	
	Name and address(es) of other treating physician(s): _____			
Hospital name: _____		Confinement dates: _____ / ____ / ____ through _____ / ____ / ____		
<b>D I A G N O S I S</b>	Diagnoses with ICD10-CM codes: list in decending order of severity (including any complications). Please go to the appropriate assessment section and elaborate. ICD-10 _____			
	Subjective symptoms: _____			
	Objective findings: _____			
<b>T R E A T M E N T</b>	Date of first visit: _____ / ____ / ____	Date of last visit: _____ / ____ / ____	Frequency: _____ Weekly _____ Monthly _____ Other	
	Nature of treatment (including surgery, medications, therapies prescribed, if any): _____			
	Specific restrictions and limitations: _____			
<b>I M P A I R M E N T S</b>	Physical Impairments (as defined in Federal Dictionary of Occupational Titles)			
	<input type="checkbox"/> Class 1 No limitation of functional capacity; capable of heavy work*. No restrictions. (0-10%) <input type="checkbox"/> Class 2 Medium manual activity*. (15-30%) <input type="checkbox"/> Class 3 Slight limitation of functional capacity; capable of light work*. (35-55%) <input type="checkbox"/> Class 4 Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity. (60-70%) <input type="checkbox"/> Class 5 Severe limitation of functional capacity; incapable of minimum (sedentary*) activity. (75-100%)			
	Remarks: _____			
	Mental Impairments (If Applicable)			
<b>P R O G N O S I S</b>	a. Please define "stress" as it applies to this patient _____			
	b. What stress and problems in interpersonal relations has patient had on the job?			
	<input type="checkbox"/> Class 1 Patient is able to function under stress and engage in interpersonal relations (no limitations) <input type="checkbox"/> Class 2 Patient is able to function under stress and engage in interpersonal relations (slight limitations) <input type="checkbox"/> Class 3 Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations) <input type="checkbox"/> Class 4 Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations) <input type="checkbox"/> Class 5 Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)			
	Remarks: _____			
	Is patient now totally disabled?      Patient's Job    _____ Yes    _____ No	Date patient became disabled due to present illness _____ / ____ / ____		
	Any Other Work    _____ Yes    _____ No	If not disabled was patient released to return to work? _____ Yes    _____ No      _____ Full Duty    _____ Restricted Duty		
When do you expect a fundamental or marked change in the future? _____ 1 Month    _____ 1-3 Months    _____ 3-6 Months    _____ Never	If still disabled, date patient should be able to return to work _____ / ____ / ____			
Patient was continuously disabled (unable to work): From _____ / ____ / ____ To _____ / ____ / ____	Date of next scheduled appointment: _____ / ____ / ____			
Reason unable to work, in detail: _____				
The above statements are true and complete to the best of my knowledge and belief				
Physician Name (Please Print) _____		Degree/Specialty (must be signed by Medical Doctor - MD or Doctor of Osteopathic - DO) _____	Telephone (    ) _____	
Address (Street, City, State, Zip) _____				
Signature _____		Tax Identification # _____	Date _____	



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## CLAIM FOR SHORT-TERM DISABILITY BENEFITS

### PART III EMPLOYER'S STATEMENT (ALL QUESTIONS MUST BE ANSWERED TO AVOID DELAY)

Employer Name		Employer Phone Number (      )	
Employer Address (Street, City, State, Zip)			
Employee Name		Employee Social Security Number _____-_____-_____	
		Employee Date of Birth      /      /	
Actual last day worked ____/____/____	Normal Work Schedule	Mon	Tues
____ Hours worked	____ Hours/Day	Wed	Thurs
	____ Hours/Week	Fri	Sat
		Sun	
Date Employee Terminated ____/____/____	Reason for leaving work    ___ Disability    ___ Resigned    ___ Terminated ___ Layoff    ___ Retired    ___ Leave of Absence		
Can the employee's job be modified to allow for return to work? ___ Yes    ___ No    ___ Maybe, depending on restrictions		Date employee returned to work ____/____/____ ___ Full Time    ___ With Restrictions	
Did this Disability arise out of employment?    ___ Yes    ___ No    If yes, please explain			
Has a Workers' Compensation Claim been filed?    ___ Yes    ___ No			
Will this employee receive sick/leave/vacation pay after their Last Day Worked?    ___ Yes    ___ No <i>If Yes, complete dates below.</i>			
Date payments begin      /      /		Date payments end      /      /	
Employee's Job Title			
Brief description of major job duties			
<b>Please contact the employee's direct supervisor and then CIRCLE the strength demand which best describes the employee's job:</b>			
<b>S - Sedentary</b>	10 Lbs Maximum lifting, occasional lift/carry of small articles. Some occasional walking or standing required		
<b>L - Light</b>	20 Lbs Maximum lifting with frequent lift/carry up to 10 Lbs. A job is light if less lifting is involved but significant walking/standing is done or if done mostly sitting but requires push/pull on arm or leg controls.		
<b>M - Medium</b>	50 Lbs Maximum lifting with frequent lift/carry up to 25 Lbs.		
<b>H - Heavy</b>	100 Lbs Maximum lifting with frequent lift/carry up to 50 Lbs.		
<b>V - Very Heavy</b>	Over 100 Lbs lifting with frequent lift/carry over 50 Lbs.		
<b>The above statements are true and complete to the best of my knowledge and belief</b>			
Name of person completing form (please print)		Telephone Number (      )	
Title of person completing form	E-mail address	Fax Number (      )	
Signature		Date Signed	

PLEASE NOTIFY THE FUND OFFICE WHEN THE EMPLOYEE RETURNS TO WORK AT 708-482-0110

**HIPAA AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FOR  
SHORT-TERM DISABILITY BENEFITS**

**Member Name** \_\_\_\_\_ **ID#** \_\_\_\_\_ **DOB** \_\_\_\_\_

**Persons/Categories of persons providing the information:** Any provider of medical services, insurance company, Social Security Administration, governmental agency, vocational provider or employer having medical information with respect to any physical or mental condition of mine.

I hereby authorize the use or disclosure of my protected health information as described below to the **Automobile Mechanics' Local 701 Welfare Fund**.

**Information to be disclosed:** All information necessary to allow the Automobile Mechanics' Local 701 Welfare Fund or its representatives to determine my eligibility for short-term disability benefits and to process my disability claim. Such information may include, but is not limited to: Any and all medical/dental records relating to my physical and/or mental health whether for treatment or evaluation purposes, pharmacy records and strength/functional testing.

**The sole purpose of this disclosure is for the adjudication of my claim for short-term disability benefits.**

I understand the following:

- This authorization is voluntary and I may revoke it at any time by contacting the Automobile Mechanics' Local 701 Welfare Fund but any such revocation will not affect any actions that the Automobile Mechanics' Local 701 Welfare Fund took before receipt of the revocation.
- I may refuse to sign this authorization; however, if I refuse to sign this authorization I may not receive short-term disability benefits under the plan.
- I agree that photocopies of this authorization shall be as valid as the original.
- I may inspect and/or copy the health information described above.
- My medical treatment or payment of medical benefits cannot be conditioned upon whether I sign this authorization.
- If there is a conflict between a prior request for restrictions and this authorization, this authorization controls.
- This authorization is effective from the date signed below until my disability claim ends or 12 months from the date signed below, whichever is earlier.

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SIGNATURE OF MEMBER OR LEGAL PERSONAL REPRESENTATIVE

DATE

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PRINTED NAME OF LEGAL PERSONAL REPRESENTATIVE

RELATIONSHIP TO MEMBER

**HIPAA AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO THE AUTOMOBILE  
MECHANICS' LOCAL 701 PENSION FUND**

In addition to the above authorization, I further authorize the Automobile Mechanics' Local 701 Welfare Fund to release information regarding the duration of this period of short-term disability to the Automobile Mechanics' Local 701 Pension Fund. This authorization is effective for 12 months from the date signed below.

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SIGNATURE OF MEMBER OR LEGAL PERSONAL REPRESENTATIVE

DATE

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PRINTED NAME OF LEGAL PERSONAL REPRESENTATIVE

RELATIONSHIP TO MEMBER