Benefit Services
SERVING LOCAL UNION 725 & MCASF
15800 Pines Blvd, Suite 201, Pembroke Pines, FL 33027
info@725benefits.org | 754.777.7735

MCASF Local 725 Health and Welfare Fund
LOSS OF TIME AND/OR DISABILITY STATEMENT

SECTION A: TO BE COMPLETED BY THE PARTICIPANT CLAIMING BENEFIT FOR SELF

Full Name _____

Date of Birth _____

Social Security # _____

Marital Status
- ☐ **Single**
- ☐ **Married** **Date** _____
- ☐ **Divorced** **Date** _____
- ☐ **Widowed** **Date** _____

Address _____

PhoneNumber (_____) _____ Email _____

Employer Name _____

Is the claim for a job related injury or illness? ☐ Yes ☐ No Have you filed for Worker's Compensation? ☐ Yes ☐ No

Denied for Worker's Compensation? ☐ Yes ☐ No Date of Denial _____ Appeal Submitted? ☐ Yes ☐ No

Date Disability Began _____ Date Last Worked_____ Is any part of this disability due to your job ☐ Yes ☐ No

Is the claim a result of an accident? ☐ Yes ☐ No (If yes, answer questions below) Is the accident auto-related? ☐ Yes ☐ No

A. Where did the injury occur? _____ Date & Hour _____
B. What were you doing when the injury occurred? _____
_____
C. Describe the injury; Tell how it happened _____
_____

If accident is auto-related;
Name of Insurance Company _____ Policy # _____
Address of Insurance Company _____ Cert No. _____

The above answers are true and complete according to the best of my knowledge and belief. I authorize any employer, insurance company, dental/medical prepayment plan, employee welfare benefit (including the Trust), service organization, physician, practitioner or other person and hospital, including the Veteran's Administration or other institutions, to release or, obtain any medical/dental benefit information that may be required to establish or support the validity of this claim and further authorize said company, person or organization (including the Trust) in its discretion, to disclose to any person, company or organization so requesting my personal dental/medical or claim information obtained in any case study or claim review. A copy of this authorization shall be as the original. I also acknowledge the subrogation right of the Plan, and additionally agree to repay any sums expended by the Plan for injury or sickness from caused or resulting from intentional acts or negligence of another party or source. Additionally, should I receive any payment pursuant to this statement which I am presently or my become ineligible to receive, I agree to return same, and to the Plan's imposition of a reduction in credit hours that may have been afforded/credited to me as a consequence thereof. "See Summary Plan Description".

Signature _____ Date _____
Participant must sign here

SECTION B: TO BE COMPLETED BY PHYSICIAN

note to physician:

Completion of this form will assist your patient in presenting claim for group and/or individual disability benefits. please complete all areas of the form; if a section is non-applicable, please enter n/a in the response area.

1a Patient's last name	1b Patient's first name	1c M.I.	2 Birthdate (mm/dd/yyyy)

3 Current diagnosis	4 ICD-9 code/DSM IV

5 Subjective findings	6 Objective findings

7 Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, please specify dates of treatment:	8 Did injury or illness arise out of or in course of employment ? ☐ Yes ☐ No ☐ Unknown If yes, please explain:

9 Was patient hospitalized? ☐ Yes ☐ No If yes, please provide dates of confinement and name of hospital/facility:	10 Nature of surgical procedure, if any. (Describe in full.) Date performed (mm/dd/yyyy): _____

TREATMENT

11 Date patient first unable to perform job duties (mm/dd/yyyy)	11 Date of first visit (mm/dd/yyyy)	12 Date of last visit (mm/dd/yyyy)

13 Patient's present condition ☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed	14 Frequency of visits ☐ Weekly ☐ Monthly Other: _____

15 Treatment plan

16 Functional impairments	

EXTENT OF DISABILITY

17 Patient released to return to work? ☐ Yes ☐ No

If yes: ☐ Full-time, no restrictions Date return to full duty:

☐ Light duty (Please specify restrictions, limitations, hours, graduated return to work schedule, etc.):

Date return to light duty (mm/dd/yyyy): _____

If no: Estimated date to return to work: (mm/dd/yyyy):_____

PHYSICIAN INFORMATION

18a Physician printed last name	18b Physician first name	18c M.I.	19 Physician specialty

20a Physician street address	20b City	20c State	20d ZIP code

21 Physician phone no.	22 Physician fax no.	23 Physician e-mail address

Signature of physician X	Date (mm/dd/yyyy)

MCASF Local 725 Health & Welfare Trust Fund

Loss of Time (Short-Term Disability) Benefit

15800 Pines Blvd., Suite 201 Pembroke Pines, FL 33027
Phone (754) 777-7735 Fax (754) 999-2205

Direct Deposit

The BEST way to receive your weekly disability benefit

And here's why…

Direct deposit is ***safe*** because your benefit payment is automatically deposited into your bank account – no more worrying about lost or stolen checks or delays caused by mail service.

Direct deposit is ***fast*** because no matter if you are sick or away from home, your check is still deposited into your account. No more standing in long bank lines or waiting for your check to clear.

Direct deposit is ***easy*** because your benefit payment is deposited into your checking or savings account on time, correctly and confidentially.

Please take a few minutes and complete the form on the back so you can take advantage of the benefits of Direct Deposit. It will take the Fund Office about 30 days after it receives your authorization to set up the procedure with your bank. Please be assured there will be no interruption in your monthly benefit and there is no cost to you.

*****IMPORTANT*****

Please notify the Fund Office *immediately* whenever you change your address so that our records will be updated, and you will continue to receive your monthly direct deposit.

MCASF Local 725 Health & Welfare Trust Fund
DIRECT DEPOSIT AGREEMENT

Name of Payee_____Social Security No _____

Address _____

City_____State_____Zip_____

Telephone No ( ) _____

Bank Account Information *– Attach a voided check from your account and/or complete the information below. See sample check at the bottom of the page for help completing this section.*

Routing No._____ Account No._____

Type of Account: ☐ Checking ☐ Savings

Financial Institution

Name _ _____

Address_____

City_____State_____Zip_____

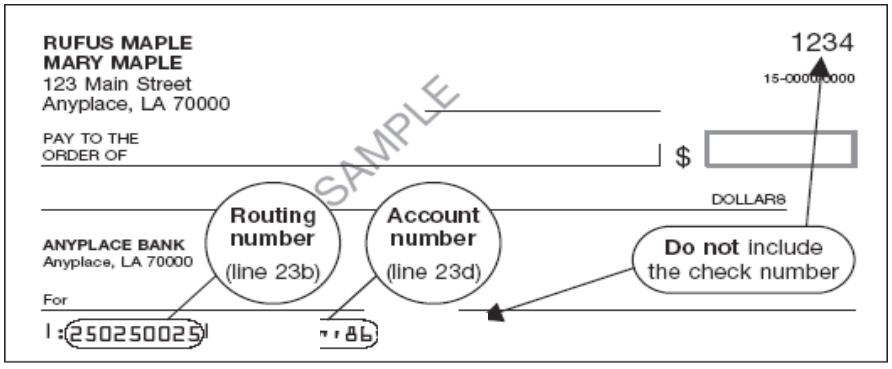
Telephone Number _ _____

Please allow up to 30 days for the direct deposit set-up process to be completed.

I, the undersigned, hereby authorize the Board of Trustees of the Health & Welfare Trust Fund ("the Health Fund") to deposit all amounts due to me under the Loss of Time Benefit provision in my account at the Financial Institution named above. This authorization shall remain in force until I revoke it in writing or until my death, whichever occurs first. If at any time the Health Fund should credit my account for a benefit to which I am not entitled, I authorize and direct the Financial Institution to refund the Health Fund.

_____ _____

Payee Signature Date



Note: *The routing and account numbers may be in different places on your check.*