Dear Member:

The EIT Benefit Funds office has received notification that you are unable to work due to an injury or illness that is work related. If you are unable to work because of a certified disability, you may be credited hours for each week of proven disability during any one period of continuous disability.

To receive credited hours, you must be:

- Covered under the Plan at the time of your injury or illness (not including COBRA continuation coverage); and
- Receiving disability benefits from a Workers' Compensation Provider; and
- Provide a copy of your 1st and most recent disability payment from the Workers' Compensation Provider; and
- Effective November 1, 2015, your Workers' Compensation Disability Statement must be completed and filed with the EIT Benefit Funds office within 90 days of the last day you worked contributed hours or the date of your injury or illness. **Claims filed after 90 days will not be accepted and no Disability Hours will be credited to maintain your health insurance.**

Enclosed please find the Workers' Compensation Disability Statement. This statement must be completed by you, your employer and your attending physician. Please note that each section must be completed in its entirety. Before submitting the completed form to EIT, please review it for completeness and accuracy. Incomplete forms may result in a delay or denial of benefits.

If you have any questions regarding this matter, please feel free to contact the EIT Benefit Funds Office at (312) 782-5442.

Sincerely,
Workers' Compensation Dept.
EIT Benefit Funds

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EIT BENEFIT FUNDS
SERVING THE CHICAGO ELECTRICAL INDUSTRY SINCE 1930

Workers' Compensation Disability Statement

Section 1: Participant - *Complete with your information.*

Name:	**Last 4 of SSN:**	**Birth Date:**
Street Address:		**Apt #:**
City:	**State:**	**Zip Code:**
Phone: ( )	**Email:**	

Accident Information: *Please provide information below.* ***If you have copies of any accident reports, please provide them to the Fund Office.***

Date of Accident:	**Location of Accident (City & State):**
Last Day Worked:	**Returned To Work Date (if applicable):**

Brief Description of the Accident:

Participant Signature: ***The form must be signed and date below.***

I hereby certify that all of these statements in Sections 1, 2 and 3 are true and complete to the best of my knowledge and belief.

Participant's Signature: _____ **Date:** _____

Section 2: Workers' Compensation Claim Information - *You must provide your Workers' Compensation claim information.*

State & County Where Claim Filed:

Claim Name:

Claim #: **Year Filed:**

Have you received <u>any Temporary Compensation</u> from your Employer or its insurance carrier because of this Accident?

☐ **No** ☐ **Yes** *(you must attach a copy of your first and most recent check stub and list all dates payment have been received below)*

Have you filed an Application for Adjustment of Claim or any other document to begin your claim with the applicable court or government agency?

☐ **No** ☐ **Yes** *(you must provide copies of all relevant documents filed with the applicable court or government agencies)*

Has your Employer's Workers' Compensation insurance carrier denied payment of the medical bills you have submitted relating to the Accident?

☐ **No** ☐ **Yes** *(you must provide copies of any written claim denials from your Employer's Workers' Compensation Insurance carrier)*

Section 3 and 4 continued on page 2.

Workers' Compensation Disability Statement

Section 3: Attorney Information – *Only complete Section 3 if you are being represented by an Attorney in this case.*		
Participant Name:		
Attorney Name:		
Law Firm:		
Street Address:		
City:	**State:**	**Zip Code:**
Phone: ( )	**Email:**	

Section 4: Employer Information – *Your employer must complete Section 4.*		
Employer Name:		
Employer Contact:		
Street Address:		
City:	**State:**	**Zip Code:**
Phone: ( )	**Email:**	
Employee's Last Day Worked:		
Workers' Compensation Insurance Carrier Information: *Please provide information below.*		
Employer's Insurance Company:		
Claims Representative:		
Policy#:	**Claim #:**	
Policy Limits:		
Street Address:		
City:	**State:**	**Zip Code:**
Phone: ( )	**Email:**	
Employer's Signature:		**Date:**

Section 5 continued on page 3.

EIT BENEFIT FUNDS
SERVING THE CHICAGO ELECTRICAL INDUSTRY SINCE 1930

Workers' Compensation Disability Statement

Section 5: Attending Physician's Statement – *To be completed in its entirety by your doctor.*

Patient Name:

Diagnosis

Primary: **ICD.9**

Secondary: **ICD.9**

Progress

Frequency of treatment:
☐ Weekly ☐ Monthly ☐ Other :

Patient has:
☐ Recovered ☐ Not Changed ☐ Improved ☐ Regressed

Dates of continuous TOTAL disability:
From: To:

Dates of continuous PARTIAL disability:
From: To:

Extent of Disability

Is patient able to perform the duties of his/her job? ☐ Yes ☐ No **Any occupation?** ☐ Yes ☐ No

If patient IS totally disabled:
When will patient be able to return to work? Date: _____ ☐ Never ☐ Indefinite

Is patient a suitable candidate for a rehabilitation program? ☐ Yes ☐ No

If patient IS NOT totally disabled:
Will this disability prevent the patient from engaging in any meaningful occupation for his/her lifetime? ☐ Yes ☐ No

When was patient able to return to work? Date: _____

Which level of function, as defined by the U.S. DOL, best describes the patient's ability to perform his/her job duties?
☐ Sedentary Work ☐ Light Work ☐ Medium Work ☐ Heavy Work ☐ Other/Restrictions _____

Cardiac Condition: *Complete only if disability is due to heart condition. Functional capacity based on American Heart Association.*

☐ No Limitations ☐ Marked Limitations ☐ Slight Limitations ☐ Complete Limitations

Physician Information

Physician Name:

Street Address:

City: **State:** **Zip Code:**

Phone: **Fax:**

Physician's Signature: **Date:**

Return your completed Workers' Compensation Disability Statement