United Food and Commercial Workers
Union and Employers Calumet Region Insurance Fund
Administered by Wilson-McShane Corporation

1431 Opus Place, Suite 350
Downers Grove, IL 60515

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Fax: (847) 384-0197
Toll Free: (800) 621-5133
www.ufcwbenefitfunds.com

Disability Claim Form - For Income Protection Benefits

NOTE: YOU MUST ANSWER ALL QUESTIONS COMPLETELY FOR THE CLAIM TO BE PROCESSED

TO BE COMPLETED BY MEMBER/PATIENT:

1. Personal Information

Your Name: _____

Social Security Number: _____

Date of Birth: _____

Address: _____

_____

2. Authorization to release information:

I hereby authorize the undersigned physician to release any information acquired in the course of my examination or treatment. I also make claim for benefits and certify that the statements under Part A are true and complete to the best of my knowledge.

_____ _____
Signature of Insured Date

3. State last day worked because of disability:

_____ / _____ / _____
month day year

4. On what date were or will you be able to perform full-time work:

_____ / _____ / _____
month day year

5. If injured, how and where did the accident occur?

6. Did injury occur in the course of employment? ❑ Yes ❑ No

7. Have you or do you intend to file this claim under Workers' Compensation?

❑ Yes ❑ No

8. Are you now engaged in the duties of any occupation or endeavor for wages, profits or compensation?

❑ Yes ❑ No

MEMBER PHONE # NAME OF EMPLOYER DATE LAST EMPLOYED

I CERTIFY THAT THE ABOVE INFORAMTION IS TRUE AND CORRECT. I HERBY AUTHORIZE ALL DOCTORS, HOSPITALS OR OTHER INSTITUTIONS RENDERING CARE AND TREATMENT TO FURNISH THE UFCW UNIONS AND EMPLOYERS CALUMET REGION INSURANCE FUND WITH FULL INFORMATION REGARDING TREATMENT RENDERED, INCLUDING COPIES OF THEIR RECORDS. I ALSO AUTHORIZE ANY UNION TRUST FUND, EMPLOYER OR INSURANCE CARRIER TO FURNISH THE UFCW UNIONS AND EMPLOYERS CALUMET REGION INSURANCE FUND WITH INFORMATION REGUARDING BENEFITS TO WHICH I OR ANY OF MY DEPENDENTS MAY BE ENTITLED TO.

DATE MEMBER'S SIGNATURE

TO BE COMPLETED BY EMPLOYER:

1. FIRST FULL DAY UNABLE TO WORK:	2. LAST DATE AND TIME WORKED:	3. DATE RETURNED TO WORK:	4. DID DISABILITY OCCUR DUE TO OCCUPATIONAL CAUSES? ☐ YES ☐ NO
5. HAS EMPLOYMENT TERMINATED? ☐ YES ☐ NO	WHEN?	REASON?	
6. BASIC GROSS WEEKLY EARNINGS:	7. WILL A CLAIM BE MADE UNDER WORKER'S COMPENSATION? ☐ YES ☐ NO		

8. 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	
9. PRIOR TO THIS DISABILITY, WAS THE EMPLOYEE	☐ LAID OFF	☐ ON LEAVE	☐ RETIRED	☐ DISCHARGED	☐ QUIT
AUTHORIZED SIGNATURE	PRINTED NAME				
DATE	**PHONE NUMBER**				

ATTENDING PHYSICIAN'S STATEMENT ON REVERSE SIDE

United Food and Commercial Workers Unions and Employees Calumet Region Insurance Fund

Statement of Claim – For Income Protection Benefits

TO BE COMPLETED BY MEMBER/PATIENT:

PATIENT'S NAME	DATE OF BIRTH	SOCIAL SECURITY NO

PATIENT'S ADDRESS	CITY	STATE	ZIP	PHONE

CLAIMANT'S ASSIGNMENT (READ BEFORE SIGNING):

I HEREBY AUTHORIZE THE UFCW UNIONS AND EMPLOYERS CALUMET REGION INSURANCE FUND TO PAY DIRECTLY TO THE ABOVE NAMED PHYSICIAN THE MEDICAL OR SURGICAL EXPENSE BENEFITS TO WHICH I AM ENTITLED UNDER THE TERMS OF THE PLAN TO THE EXTENT OF HIS INTEREST AS ESTABLISHED HEREWITH.

_____ _____

SIGNATURE OF CLAIMANT DATE

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.

TO BE COMPLETED BY ATTENDING PHYSICIAN:

1. Diagnosis and concurrent conditions:

2. Frequency of visits:

❑ Weekly ❑ Monthly ❑ Other:_____

3. Is patient totally disabled from any occupation?

❑ Yes ❑ No

Date patient became totally disabled: _____ /_____ /_____
month day year

4. Is patient totally disabled from his/her regular occupation?

❑ Yes ❑ No

Date patient became totally disabled: _____ /_____ /_____
month day year

5. On what date will the patient be able to resume normal activities and return to work?

_____ / _____ / _____
month day year

6. Attending Physician's Information:

Physician's Name: _____

Physician's Signature:_____

Degree:_____ Date:_____

Address:_____

_____

7. Remarks:

_____

_____

_____

_____

_____

11. DOES PATIENT HAVE OTHER HEALTH COVERAGE?

☐ YES ☐ NO IF YES, PLEASE IDENTIFY

Return Completed Forms To:
UFCW Benefits Fund Office
c/o Wilson-McShane Corporation
1431 Opus Place, Suite 350
Downers Grove, IL 60515