



MCAF Local 725 Health and Welfare Fund

15800 Pines Blvd, Suite 201 Pembroke Pines, FL 33027
P 754.777.7735 | F 754.999.2205 | E info@725benefits.org | W www.725benefits.org

LOSS OF TIME AND/OR DISABILITY STATEMENT

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

Marital Status

- Single
Married Date
Divorced Date
Widowed Date

Full Name

Date of Birth Social Security #

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



IT IS UNLAWFUL TO FILE A FALSE OR FRADULENT CLAIM

Part B		ATTENDING PHYSICIAN'S STATEMENT	
THIS FORM MUST BE COMPLETED & SIGNED BY THE ATTENDING PHYSICIAN/PROVIDER ONLY			
Patient's Name		Date of Birth	
Date Patient Able to Return to Work	Date of Total Disability (Estimate if Not Known)		
	From	Through	
Name & Address of Facility Where Services Rendered (If other than Home or Office)			
Name: _____			
Address: _____			

Diagnosis or Nature of Illness or Injury Related <u>Diagnosis to Procedure in Column by Reference to Number 1,2,3, ETC OR DX Code</u>			
1 _____			
2 _____			
3 _____			
4 _____			
I attest the information noted above is accurate and truthful based on information provided to me and upon my review and examination of the information and patient.			
Attending Physician/Provider Signature _____		Date _____	
Name: _____		Facility: _____	
Address: _____			
Phone: _____		Fax: _____	

***PLEASE USE CURRENT PROCEDURAL TERMINOLOGY CODES FOR SURGERY**

21. (H) INPATIENT HOSPITAL
 22. (OH) OUTPATIENT HOSPITAL
 11. (O) DOCTORS OFFICE

12. (HJ) PATIENTS HOME
 12. DAY CARE FACILITY (PSY)
 12. NIGHT CARE FACILITY (PSY)

32. (NH) NURSING HOME
 31. (IL) SKILLED NURSING FACILITY
 41. AMBULANCE

0. (OL) • OTHER LOCATIONS
 81. (IL) INDEPENDENT LABORATORY
 B. OTHER MEDICAL/SURGICAL



Part C

EMPLOYER'S STATEMENT

To Be Completed by Employer only if the Participant's lost time from work and is subject to a Worker's Compensation claim
(Required on Initial Filing Only)

Employee's Name: _____

Employer Information

Name: _____

Address: _____

Phone: _____ Fax: _____

Injury Information

Is Illness or Injury due to Occupational Causes? Yes No Worker's Compensation Claim Filed? Yes No

Date of Injury _____ Date Last Worked _____ Date Returned to Work _____

I attest the information noted above is accurate and truthful based on information provided to me and upon my review of the information and/or injury report.

Employer's Signature _____ Date _____

Name _____ Title _____

(Please Print)