The Union Labor Life Insurance Company

STATEMENT OF CONTINUANCE OF DISABILITY

INSTRUCTIONS: This form must be submitted by the individual claimant to the office of the Policyholder properly and fully completed, and signed by himself, and his physician.

TO BE COMPLETED BY INSURED EMPLOYEE

1. WHAT IS YOUR FULL NAME? ______________________ SOC SEC # ____________
2. WHAT IS YOUR HOME ADDRESS? ______________________

   STREET CITY STATE

3. ARE YOU STILL TOTALLY DISABLED BY THIS SICKNESS OR INJURY? ____________
4. ARE YOU NOW WHOLLY UNABLE TO PHYSICALLY ENGAGE IN ANY WORK, OCCUPATION OR BUSINESS? ____________
5. ON WHAT DATE WERE YOU LAST TREATED BY A PHYSICAN? ____________
6. HAVE YOU RETURNED TO WORK? ____________ IF SO, ON WHAT DATE? ____________

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

DATE: ____________ SIGNATURE OF INSURED EMPLOYEE: ____________

TO BE COMPLETED BY POLICYHOLDER

NAME OF POLICYHOLDER

I.A.T.S.E. National Health & Welfare Fund

ADDRESS OF POLICYHOLDER

417 5th Avenue, 3rd Floor, New York, NY 10016 * 1-(800)-456-3863**

GROUP POLICY NUMBERS	CERTIFICATE NUMBER	
C-3561		
DATE	SIGNATURE OF POLICHOLDER'S REPRESENTATIVE	

CLM-8N

(over)

ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

(1) Patient's name ______________________________ Age ____________

(2) Nature of sickness or injury (Describe complications, if any) ______________________________

____

____

____

(3) (a) Date of first treatment ______________________________ 20______

(b) Date of most recent treatment ______________________________ 20______

(c) Frequency of treatments ______________________________

(4) The patient has been continuously disabled (unable to work) from ____________20______ through ____________ 20______

If still disabled, when should patient be able to return to work? ______________________________ 20______

(5) Remarks: ______________________________

____

____

____

Date ______________________________, 20 ________

Signed ______________________________M.D.
(Attending Physician)

Address ______________________________

____

Physician's Tax Id. No. ______________________________

(Must be furnished under authority of law.)

Phone ______________________________

(GDS-1)

THE UNION LABOR LIFE INSURANCE COMPANY

WEEKLY ACCIDENT and SICKNESS BENEFITS CLAIM

MAIL TO:

I.A.T.S.E. NATIONAL HEALTH AND WELFARE FUND
417 5th Avenue, 3rd Floor, New York, NY 10016 *** 1-(800)-456-3863

IMPORTANT: All itemized receipt bills substantiating this claim must be attached. Upon completion of treatment (or during treatment if bills are received at intervals) submit a completed claim form no later than 180 days from the date(s) of service. Failure to comply with this requirement will jeopardize your benefit payment.

TO BE COMPLETED BY MEMBER (Please Print)

Member's Last Name	First Name	Middle Initial	Birthdate	Sex	Social Security Number
Street Address	City	State	Zip Code		Telephone Number ( )
Union Local Number	Date of Entry Into Industry	Name of Current Employer(s)			

ACCIDENTS

Is this claim based on an accident? Yes ☐ No ☐

If Yes, give date ____________ time ____________ ☐ a.m. ☐ p.m. and location ____________

How did the accident occur? ____________

____

____

Date you last worked prior to your current disability ____________

First date you were physically unable to work ____________

Date you returned or were available for work ____________

Have you planned or instituted action against any party because of any injury or illness you sustained in the accident? Yes ☐ No ☐

Were any of the medical services or supplies for which this claim is being made furnished or paid for by a Government Agency? Yes ☐ No ☐

NOTICE

Any person who knowingly and with intent to defraud any insurance company files a statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize any insurance company, prepayment organization, employer, hospital or doctor, to release all information with respect to myself or any of my dependents which may have a bearing on the benefits under this or any other plan providing benefits or services. I certify that the information I have provided in support of this claim is true and correct.

Date ____________ **Member's Signature** ____________

TO BE COMPLETED BY MEMBER'S EMPLOYER (Please Print)

Dates of member's continuous employment: From ____________ To ____________

Last date of work prior to current disability ____________ Weekly Wage $ ____________

Is the disability a result of injury or occupational disease arising out of or in the course of employment? Yes ☐ No ☐

If the cause is occupational has it been reported to a state board or commission or to any insurance company as a worker's compensation claim? Yes ☐ No ☐

If not, please state the reason(s): ____________

____

____

If the member has returned to work,indicate date ____________ ____________

Employer's EIN Number

____

Employer's Name and Address

Employer Representative's Signature ____________ Title ____________ Date ____________

IMPORTANT: An itemized receipted bill must be attached.

TO BE COMPLETED BY SURGEON, PHYSICIAN OR SUPPLIER (Please Print)

1. PATIENT'S NAME ______ (Last) (First) (Middle)

2. AGE ______

3. ILLNESS ______ DATE OF FIRST SYMPTOMS
INJURY ______ DATE OF ACCIDENT
PREGNANCY ______ DATE OF LMP

4. DATE THE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION

5. HAS THE PATIENT EVER HAD THE SAME OR SIMILAR SYPMTOMS? Yes ☐ No ☐

6. IS THE CONDITION DUE TO AN INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? Yes ☐ No ☐

7. IS THE CONDITION RELATED TO AN AUTO ACCIDENT? Yes ☐ No ☐

8. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED *(if other than home or office)*:

9. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? Yes ☐ No ☐

10. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY REQUIRING SERVICES OR SUPPLIES (RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE TO NUMBER 1, 2, 3, ETC. IN COLUMN E)

1.

2.

3.

11.

A DATE OF EACH SERVICE	B PLACE OF SERVICE *See codes below	C PROCEDURE CODE (IDENTIFY: C.P.T.)	D DESCRIBE SURGICAL OR MEDICAL PROCEDURES AND OTHER SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES)	E ICDA Diagnosis Code	F CHARGES (Explain unusual circumstances in Column G)	G 	 COMMENTS

12. TO YOUR KNOWLEDGE, DOES THE PATIENT HAVE OTHER HEALTH INSURANCE OR HEALTH PLAN COVERAGE? Yes ☐ No ☐

IF YES, PLEASE IDENTIFY ______

13. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER.

14. SOCIAL SECURITY NUMBER

15. IRS TAXPAYER NUMBER

16. TOTAL CHARGES $

17. AMOUNT PAID $

18. BALANCE DUE $

PLEASE NOTE: ULLICO WILL NOT ASSIGN BENEFITS WITHOUT THE PHYSICIAN'S OR SUPPLIER'S TAX IDENTIFICATION NUMBER

19. DO YOU ACCEPT ASSIGNMENT? Yes ☐ No ☐

20. SIGNATURE OF PHYSICIAN OR SUPPLIER
I personally rendered the services described above.
SIGN HERE

21. DATE SIGNED

22. PATIENT'S ACCOUNT NUMBER

* PLACE OF SERVICE CODES

(1) Inpatient Hospital
(2) Outpatient Hospital
(3) Doctor's Office
(4) Patient's Office
(5) Day Care Facility
(6) Night Care Facility
(7) Nursing Home
(8) Skilled Nursing Facility
(9) Ambulance
(10) Other Locations
(11) Independent Laboratory
(12) Non-Hospital Surgical Facility