When complete, mail to:

UFCW Unions & Participating Employers H&W Fund
P.O. Box 1064
Sparks, MD 21152-1064

Toll Free: 1-800-638-2972

United Food and Commercial Workers Unions and Participating Employers Health and Welfare Fund

ACCIDENT & SICKNESS/WEEKLY DISABILITY CLAIM

ALL QUESTIONS MUST be answered in full or your form will be returned.

Claims must be received in the Fund office within 90 days of the date of disability

➤ *For complete instructions, please see page 4* ◄

FOR PARTICIPANT ONLY.

PARTICIPANT MUST SIGN AND COMPLETE THIS SECTION *(ITEMS 1 THROUGH 10)*

1. Name _____ Social Security # _____-_____-_____Sex _____ (Male/Female)

2. Address _____

   City _____ State _____ Zip _____ Phone _____

3. Date disability began _____ (Month/Day/Year) Date (or estimated date) of return _____ (Month/Day/Year)

4. Employer's Name _____

5. Did your disability result from an accident on your job? Yes ☐ No ☐ If yes, give details: _____

   _____ Date of injury _____ (Month/Day/Year)

6. Have you applied for workers' compensation? Yes ☐ No ☐

7. Result: Accepted ☐ Denied ☐ (Enclose copy of denial letter)

8. Have you received vacation pay, holiday pay or personal holiday pay during the period of disability?

   Yes ☐ No ☐ If yes, list actual dates paid _____ (Month/Day/Year)

9. Is your disability due to an accident? Yes ☐ No ☐

10. *If the disability is due to any type of accident,* complete the subrogation/accident inquiry on the last page. Answer all applicable questions.

I hereby certify that the foregoing statements including any accompanying statements are true, correct and complete to the best of my knowledge and hereby further authorize my attending physician, practitioner, or hospital in which confinement took place to furnish and disclose all facts concerning my physical condition that are within their knowledge.

_____

Employee Signature *Date*

FOR PHYSICIAN ONLY.

PHYSICIAN MUST SIGN AND COMPLETE THIS SECTION *(Items 11 through 18)*

11. Nature of sickness or injury *(Describe complication, if any)* _____

12. Did this sickness or injury occur as a result of patient's employment? Yes ☐ No ☐ If yes, explain: _____

    _____

13. Is disability due to pregnancy? Yes ☐ No ☐ Expected date _____ (Month/Day/Year)

Continued

Claims must be received in the Fund office within 90 days of the date of disability

14. Nature of surgical or obstetrical procedure *(Describe)* _____

_____ Date Performed _____
Month/Day/Year

15. All dates of treatment in office on or after date of disability _____

_____

Specify if Home Visit or Telephone Consultation

_____

Hospital (specify inpatient, outpatient, emergency room) *Date Admitted* *Date Discharged*

16. Unable to work from _____ When should patient be able to return to work? _____
Month/Day/Year Month/Day/Year

17. Print Name _____

Address _____

City _____ State _____ Zip _____ Phone _____

18. _____
Signature *Date*

FOR EMPLOYER ONLY. **EMPLOYER MUST SIGN AND COMPLETE THIS SECTION *(ITEMS 19 THROUGH 29)***

19. Accident ☐ Illness ☐ 20. Date Last Worked_____Date *(or Estimated Date)* of Return _____
Month/Day/Year Month/Day/Year

21. Employee's Weekly Gross Straight Time Wage $_____ Hourly Rate of Pay $_____

22. Date of Hire _____Regular Day Off (Full Time Only) _____ Average Weekly Hours_____
Month/Day/Year

23. Has vacation, personal holiday or holiday pay been paid? Yes ☐ No ☐ _____
Month/Day/Year

24. Has employee left work due to: Leave of Absence ☐ Dismissal ☐ Suspension ☐ Temporary Layoff ☐
Quit ☐ Accident and Sickness *(Disability)* ☐

25. Will employee be entitled to claim benefits for this disability under any Workers' Compensation Law or Occupational Disease Law? Yes ☐ No ☐

26. Do you have any reason to question the validity of this claim? Yes ☐ No ☐

27. Company _____ Store Number _____
(If Applicable)

28. Store Manager _____ 30. Phone ( )_____
(Print)

29. _____
Authorized Employer Representative's Signature *Date* *Print Authorized Representative's Name*

Claims must be received in the Fund office within 90 days of the date of disability

ACCIDENT INQUIRY

If benefits sought are due to any type of accident or injury, you must complete this section. Your failure to supply the complete information requested will cause a delay in processing your claim. If a third party is involved in the accident described below, your receipt of benefits is subject to your signing and compliance with the Fund's "Subrogation, Assignment of Rights, and Reimbursement Agreement" which will be provided.

1. Date of accident _____/_____/_____ Time of accident _____ (a.m./p.m.)

   Location of accident _____
   Address *(Street or nearest cross street)* City State

2. Give full description of the accident and how you were involved: _____

   _____

   _____

3. Give the name and address of any other party involved in the accident: _____

   _____

4. Give the other party's a.) insurance company b.) policy # c.) claim #: _____

   _____

5. Give your a.) insurance company name b.) address c.) policy # d.) claim #: _____

   _____

6. If you have engaged an attorney to represent you, please give his or her name, address and telephone number:

   _____
   Name of attorney Phone

   _____
   Address City State Zip

7. Described the current status of any litigation or settlement negotiations with a third part (including insurance companies) concerning your accident: _____

   _____

   _____

8. Have you received a judgment, order, or settlement with respect to your accident? Yes ☐ No ☐

   If yes, please state the amount that you received: _____

AUTHORIZATION: I agree to reimburse the Fund from any compensation I receive from a third party for losses or expenses arising out of the accident and further agree to fully cooperate with the Fund in the recovery of benefits paid on my behalf, including providing to the Fund any information it requests regarding the accident or claims relating to it.

_____

Signature *Date*

Please Read These Important Instructions About Your Accident & Sickness Claim

*The Fund office wants to process your A&S benefit fast, but to do so we must have a complete and accurate claim form. Filing your A&S claim will require the cooperation of both your physician and employer representative. Please see the explanation for some blanks on the claim form. Original A&S claims must be received by the Fund office within 90 days of the date of disability. Continuation forms, (for claims in progress), must be returned within four weeks. Be sure to have your physician and employer representative fill out their sections and return the form to **you** for timely submission. Please read the instructions for **all** sections.*

(1) Only participants are eligible — no dependents are eligible for Accident & Sickness Benefits. We use Social Security Number to locate your records. Please be sure that no numbers are transposed.

(2) Please provide your zip-plus-4 digit extension if possible. Include area code; we may need to call you to process your claim quickly.

(3) (5) **If yes, provide details on page 3, or your claim must be returned. Answer all 8 questions and sign and date the accident inquiry section.** If your accident occurred on the job, Workers' Compensation (WC) is liable, but if there is any doubt, file a claim with both WC and the Fund, to avoid denial for late submission with either party.

(6) WC claims are filed with the employer's carrier, not the Fund office.

(7) If you are in the process of filing a WC claim when you file your A&S claim with the Fund office, indicate "Unknown at this time." If your WC claim has been denied, include the denial letter. You must then appeal to the WC Commission.

(8) If your employer has paid you vacation pay, PHs, etc., you are not entitled to A&S benefits for those days.

(9)(10) An accident may be on the job or off the job. The Fund will process your claim as long as it has the right to recover from the liable party. Provide full accident details. If another party may be liable, you may receive a second form from the Fund office which requires attorney and other insurance information called a "Subrogation, Assignment of Rights" agreement. **Sign and date your section. Forms which are not signed and dated are invalid.**

(11) The Fund uses the nature of sickness or injury to determine the potential length of your absence, and to gauge the necessity and frequency of continuation forms. If your disability is related to a nervous and/or mental condition, you must be seen by a board eligible or board certified psychiatrist or licensed or certified PhD psychologist within 7 days from the date your disability began.

(13) As a diagnosis, **pregnancy** is not considered disabling. There must be a complication which prevents you from doing your job, and the physician must indicate what the medical condition is.

(14) With the diagnosis, the procedure performed allows the Fund office to estimate the length of your disability.

(15) **All** dates should be included. Fund rules require that treatment must occur **during the period of disability,** not before. (If you see a physician and are disabled, work another day or more, and then begin your absence, you may not collect the A&S Benefits.) Also, payment will only be made up to **three days prior** to the first date of treatment. If you are absent for five days before you see the doctor, your claim will only be considered as beginning three days before the date of treatment and waiting periods still apply. The physician must be able to verify your disability within a reasonable time after the Fund begins covering you, and the Fund rule is three days. Home visits are acceptable; telephone consultations are not. The physician must **see you.**

(16) If this item is left blank, no benefits can be paid. The physician must attest to the beginning date of your disability, and the end date. If he cannot specify an end date because you are still being treated, **he must project date.** Your benefit is calculated based on a number of days you are absent. The Fund office cannot assume a number. **Tell your physician he MUST project a date for you to be paid.**

(19) The waiting period may be different for accidents vs. illnesses..

(20) The date last worked will tell the Fund office when to consider beginning payment if the physician's information indicates you were disabled on that day. If the Fund office makes an overpayment because it was not notified of a return to work, the overpayment must be paid back to the Fund.

(21) The employer representative must indicate your weekly gross straight time wage exactly, or the benefit will be calculated incorrectly.

(22) Must reference hire date to accurately calculate benefit.

(23) Vacation, PH, holiday pay. To verify that A&S will not be paid for these days.

(24) Reason for leaving work. If you are on leave of absence, dismissed, suspended, laid off or quit, for example, you are no longer eligible.

(25) The employer may know whether a WC claim has been filed.

(26) Although most claims are accurate, the Fund verifies all seeming discrepancies on claim forms. That includes items which the participant may have filled out, but which are supposed to be filled out by the physician or employer. **ONLY the physician or employer may fill out their sections.** The participant should not fill out **any blank** on those sections.

— The Fund office may require updated forms on a regular basis. —

Should you have any questions about how to fill out this form, please contact Participant Services at (800) 638-2972. We will be glad to help you. The Fund office has an excellent brochure on the Accident/Subrogation process which we can mail to you.