Mail to:
HRSA-ILA-STD BENEFITS
c/o Alicare, Inc.
P.O. Box 5453 • White Plains, NY 10602-5453
Customer Service: 1-866-975-4090 • Fax: 1-914-367-4114

HRSA–ILA

HRSA-ILA WELFARE FUND STD CLAIM FORM

SECTION #1 TO BE COMPLETED BY MEMBER/EMPLOYEE – PLEASE PRINT

MEMBER'S SOC. SEC. NO. OR I.D. NO.	FULL NAME OF MEMBER (FIRST, MIDDLE, LAST)	DATE OF BIRTH	SEX M F	JOB TITLE
ADDRESS		TELEPHONE NO.		GANG NO.

SECTION #2 TO BE COMPLETED BY MEMBER/EMPLOYEE – PLEASE PRINT

1a. HAVE YOU RECEIVED STD BENEFITS DURING THE LAST 12 MONTHS? ❑ YES ❑ NO b. IF SO, DATES: ____________

2a. LAST DATE OF WORK FOR CURRENT STD PERIOD: ____________ b. I WORKED ON THAT DAY ❑ YES ❑ NO

3a. HAVE YOU RETURNED TO WORK? ❑ YES ❑ NO b. IF YES, DATE RETURNED: ____________

4. IF YOU HAVE NOT RETURNED TO WORK, ON WHAT DATE DO YOU EXPECT TO RETURN? ____________

5a. IS DISABILITY DUE TO ILLNESS? ❑ YES ❑ NO c. DATE ILLNESS BEGAN: ____________
b. DESCRIBE NATURE OF ILLNESS: d. FIRST TREATMENT DATE: ____________

6a. IS DISABILILTY DUE TO ACCIDENT? ❑ YES ❑ NO c. DATE ACCIDENT OCCURRED: ____________
b. PROVIDE ACCIDENT DETAILS: d. FIRST TREATMENT DATE: ____________

7. IF YOU HAVE BEEN HOSPITAL CONFINED OR HAD SURGERY FOR THIS DISABILITY, PLEASE PROVIDE THE FOLLOWING INFORMATION:

a. HOSPITAL OR SURGICENTER: ____________ b. DATES: FROM: ________ TO: ________

c. HAVE YOU HAD SURGERY? ❑ YES ❑ NO d. DATE OF SURGERY: ____________

e. IF YES, TYPE OF SURGERY: ____________ f. WAS SURGERY ELECTIVE ❑ YES ❑ NO

8a. IS THIS DISABILITY THE RESULT OF YOUR EMPLOYMENT? ❑ YES ❑ NO

b. IF YES, HAS A WORKERS' COMPENSATION CLAIM BEEN FILED? ❑ YES ❑ NO

IF YOUR W.C. CLAIM WAS REJECTED, ATTACH A COPY OF THE REJECTION NOTICE

9a. DO YOU HAVE AN ATTORNEY FOR W.C. OR ANY OTHER THIRD PARTY ACCIDENT? ❑ YES ❑ NO

b. IF YES, PROVIDE NAME AND ADDRESS OF ATTORNEY:

NOTE: IF YOUR MEDICAL CONDITION IS RELATED TO YOUR EMPLOYMENT, YOU MUST SUPPLY WRITTEN DOCUMENTATION TO HRSA-ILA FROM YOUR EMPLOYER OR EMPLOYER'S INSURANCE CARRIER THAT YOUR WORK ACCIDENT IS UNDER DISPUTE OR THAT WORKERS' COMPENSATION PAYMENTS HAVE STOPPED.

10a. IS YOUR DISABILITY THE RESULT OF AN AUTOMOBILE OR OTHER VEHICULAR ACCIDENT? ❑ YES ❑ NO b. VEHICLE TYPE ____________

c. IF YES, HOW AND WHERE IT OCCURRED: ____________

NOTE: IF YOU ANSWER YES TO 8a, 9a OR 10a, YOU MUST COMPLETE A PROMISSORY NOTE AVAILABLE AT THE FUND.

11. DOES THIS CLAIM RELATE TO YOUR USE OF ALCOHOL, PRESCRIBED OR NON-PRESCRIBED MEDICATIONS OR CONTROLLED SUBSTANCES? ❑ YES ❑ NO

IF YOU HAVE ANSWERED YES, YOUR TREATMENT MUST BE PROVIDED BY COMPSYCH, THE EMPLOYEE ASSISTANCE PROGRAM. COMPSYCH MAY BE REACHED AT 1-877-595-5282.

SECTION #3 THIRD PARTY AUTHORIZATION

BY SIGNING THIS APPLICATION FOR SHORT TERM DISABILITY BENEFITS, I AGREE TO BE HONORED BY THE TERMS OF THE HRSA-ILA WELFARE FUND (THE FUND). I ACKNOWLEDGE AND AGREE THAT I WILL REIMBURSE THE FUND FOR BENEFITS PAID HEREUNDER OUT OF ANY AND ALL MONIES RECOVERED FROM A THIRD PARTY AS A RESULT OF SUIT, JUDGMENT, SETTLEMENT, OR OTHERWISE, UP TO BUT NOT EXCEEDING THE GROSS AMOUNT RECEIVED FROM THE THIRD PARTY. I UNDERSTAND THAT THE BOARD OF TRUSTEES MAY WITHHOLD OTHER HRSA-ILA BENEFITS IF THIS AGREEMENT IS BREACHED.

MEMBER SIGNATURE: ____________ DATE: ____________

I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.

MEMBER SIGNATURE **DATE**

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR 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, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR SUCH VIOLATION.

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HRSA-ILA WELFARE FUND STD CLAIM FORM

SECTION #4 MEMBER AUTHORIZATION TO RELEASE INFORMATION

I HEREBY GIVE PERMISSION AND AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM TO PERSONS WHO ADMINISTER AND EVALUATE CLAIMS FOR ALICARE, INC.

MEMBER SIGNATURE: ______________________________ DATE: ______________

SECTION #5 ATTENDING PHYSICIAN STATEMENT – INITIAL STATEMENT OF DISABILITY

FULL NAME OF PATIENT (FIRST, MIDDLE, LAST)	DATE OF BIRTH	PATIENT SSN OR ID#

DIAGNOSIS:	ICD-9

PATIENT SYMPTOMS: ______________________________

YOUR OBJECTIVE FINDINGS: ______________________________

DESCRIBE TREATMENT PROGRAM (INCLUDE MEDICATIONS): ______________________________

____

ACCIDENT ❑ DATE OF OCCURRENCE ______________ OCCUPATIONAL ❑ YES ❑ NO AUTO ACCIDENT ❑ YES ❑ NO

ILLNESS ❑ DATE SYMPTOMS FIRST APPEARED ______________ PREGNANCY ❑ YES ❑ NO EDC ______________

WAS SURGERY PERFORMED ❑ YES ❑ NO IF YES, WHAT TYPE OF SURGERY ______________ WAS SURGERY ELECTIVE ❑ YES ❑ NO

HOSPITALIZATION OR SUGICENTER: ADMIT DATE ______________ DISCHARGE DATE ______________

PROVIDE DATES FOR EACH OF THE FOLLOWING:
Processing of this claim will be delayed if any dates are omitted. Answers such as indefinite or unknown will not suffice, unless an explanation is provided.

DID YOU ADVISE PATIENT TO STOP WORK? ❑ YES ❑ NO

	MONTH	DAY	YEAR
Date patient unable to perform work/job			
First treatment date for this disability			
Most recent treatment date			
Date patient has or will be able to resume employment			

IS DATE PATIENT ABLE TO RESUME EMPLOYMENT UNKNOWN OR INDEFINITE? ❑ YES ❑ NO

IF YES, PROVIDE EXPLANATION: ______________________________

NAME OF ATTENDING PHYSICIAN (FIRST, LAST) **PLEASE PRINT**			DEGREE/SPECIALTY
ADDRESS (NO. & STREET)	(CITY)	(STATE)	(ZIP CODE)
TELEPHONE NO.	FAX NO.		
PHYSICIAN'S EIN OR SSN			
SIGNATURE OF PHYSICIAN ▶			DATE SIGNED

NO FEE CAN BE PAID FOR THE COMPLETION OF THIS FORM

Fax or mail a completed copy of this authorization to:
HRSA-ILA Welfare Fund- STD
c/o Alicare, Inc., P. O. Box 5453
White Plains, NY 10602-5453
Fax - 1-914-367-4114

Effective 10/1/2010, Alicare, Inc. is handling the Short Term Disability program provided to participating members of the HRSA-ILA Welfare Fund.

Authorization to Release My Health Care Information

Patient name: ______________________________________ Date of birth:__________________

Note: The Health Insurance Portability and Accountability Act (HIPAA) requires that we obtain this authorization from you. You are not required to sign the authorization, but if you do not, Alicare, Inc. may not be able to evaluate or administer your claim for disability. Please sign and return this authorization to the address above.

I hereby give permission and authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service; health plan; rehabilitation professional; vocational evaluator; and employer that has information about my health, employment history, or other insurance claims and benefits to disclose any and all of this information to persons who administer and evaluate claims for Alicare , Inc. and Alicare Medical Management (AMM), both affiliates of Amalgamated Life Insurance Company.

I understand that any information Alicare, Inc and AMM obtains pursuant to this authorization will be used for evaluating and administering my claim(s) for disability benefits, which may include assisting me in returning to work. I further understand that the information is subject to redisclosure and might not be protected by HIPAA.

This authorization is valid for two years from the date below or the duration of my claim, whichever period is shorter. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent Alicare, Inc. and AMM have relied on the authorization prior to notice of revocation. I understand if I revoke this authorization, Alicare, Inc. may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

______________________________ _______/________/_______

Print Name Social Security Number of Claimant

______________________________ _________________________________

Claimant/member Signature Date Signed

I signed on behalf of the claimant as ________________________ (indicate relationship). If Power of Attorney Designee, Guardian, Conservator, please attach a copy of document granting authority.

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