

Construction Industry Welfare Fund of Rockford Time Loss Claim Form <i>Please return this form to:</i> CIWFR Attn: Time Loss 195 Buckley Drive, Suite A Rockford, IL 61107 Fax # 815-399-5773		<u>Time Loss Benefits</u> <table border="0"> <tr> <td></td> <td><u>Non-Occupational</u></td> <td><u>Occupational</u></td> </tr> <tr> <td>Weekly Benefit:</td> <td>\$350 less FICA/MEDC</td> <td>\$350 less FICA/MEDC</td> </tr> <tr> <td>Max Benefit Period:</td> <td>26 weeks</td> <td>1 week</td> </tr> <tr> <td>Waiting Period:</td> <td>Accident 1st day Illness 8th day</td> <td>1st day</td> </tr> </table>			<u>Non-Occupational</u>	<u>Occupational</u>	Weekly Benefit:	\$350 less FICA/MEDC	\$350 less FICA/MEDC	Max Benefit Period:	26 weeks	1 week	Waiting Period:	Accident 1 st day Illness 8 th day	1 st day
	<u>Non-Occupational</u>	<u>Occupational</u>													
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Waiting Period:	Accident 1 st day Illness 8 th day	1 st day													
For Office Use Only <input type="checkbox"/> Eligible <input type="checkbox"/> Not Eligible		Qualifying Eligibility Hours: 5 hours per day with a max of 100 hours per month for no longer than 6 months (see SPD for lifetime max).													
A. TO BE COMPLETED BY MEMBER (please print)															
Last Name		First Name	MI												
Address															
City	State	Zip	Phone#												
Local Union #	SSN #	DOB	Date Employed												
First full day unable to work		Date returned to work													
Description of Injury or Illness:															
Is disability due to an accident? Yes <input type="checkbox"/> No <input type="checkbox"/>		Date of accident	Time												
Where did accident occur?		Describe accident:													
Is disability due to occupational cause? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, complete Section B															
Have you filed, or do you intend to file for Worker's Compensation? Yes <input type="checkbox"/> No <input type="checkbox"/>															
I hereby authorize any physician, hospital, or other medically related facility, insurance company or other organization, institution or person to release to the Construction Industry Welfare Fund of Rockford and/ or Group Administrators any records or information relating to my claim or any facts concerning my injury illness or treatment.															
_____		_____													
Member Signature		Date													
B. TO BE COMPLETED BY EMPLOYER ONLY IF OCCUPATIONAL															
Employer Name		Phone #													
Address															
City	State	Zip													
Employees Name		Is disability due to occupational cause? Yes <input type="checkbox"/> No <input type="checkbox"/>													
Date (first full day) employee was unable to work:															
Date	<input type="checkbox"/> Resumed work	<input type="checkbox"/> Expected to Resume work	<input type="checkbox"/> Terminated												
_____	_____	_____													
Employer Signature	Title	Date													

Attending Physician's Statement must also be completed and returned to the CIWFR address above.

If you have questions regarding your Time Loss, please call GAL at 815-399-0800 or 800-249-7947.