Construction Industry Welfare Fund of Rockford Time Loss Claim Form

Please return this form to:

CIWFR
Attn: Time Loss
1322 East State Street, Suite 300
Rockford, IL 61104
Fax # 847-519-1979

Time Loss Benefits

	Non-Occupational	Occupational
Weekly Benefit:	$350 less FICA/MEDC	$350 less FICA/MEDC
Max Benefit Period:	26 weeks	1 week
Waiting Period:	Accident 1st day Illness 8th day	1st day

For Office Use Only ☐ **Eligible** ☐ **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** ☐ **No** ☐	Date of accident	Time
Where did accident occur?	Describe accident:	

Is disability due to occupational cause? **Yes** ☐ **No** ☐ If yes, complete Section B

Have you filed, or do you intend to file for Worker's Compensation? **Yes** ☐ **No** ☐

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** ☐ **No** ☐
Date (first full day) employee was unable to work:	
Date ☐ Resumed work ☐ Expected to Resume work ☐ 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.

C. ATTENDING PHYSICIAN'S STATEMENT

1. Name of Patient	**DOB**	**SSN #**

2. Diagnosis – Please include the primary diagnosis and list any secondary conditions.

Date of Last Examination	Diagnosis (including any complications) include ICD9 and/or DSM IV Multi Evaluation Nomenclature and Code Number

Objective Findings (including current x-rays, EKGs, psychiatric testing, lab data and clinical findings)

Symptoms

Is this condition due to: Accident □ Sickness □	Date symptoms first appeared or accident occurred:

Is the accident or sickness related to patient's employment? Yes □ No □ Unknown □

Date restrictions and limitations began:	Has patient ever been treated for the same or similar condition? Yes □ No □ If yes, state when and describe.

3. Information About the Patient's Ability to Work – Information is critical to understanding your patient's condition.

Has patient been released to work in his/her occupation? Yes □ No □ In any occupation? Yes □ No □

If patient has demonstrated a loss of function, please provide restrictions and limitations and the date they began in the space provided below.

Fully describe restrictions and limitations.
Restrictions (What the patient should not do)

Limitations (What patient cannot do)

Patient continuously totally disabled dates **(Claim can not be processed without this information)**	**DISABILITY DATE FROM:**	**DISABILITY DATE TO:**	
If pregnant, expected delivery date	If delivered, actual delivery date	Delivery type: Normal □ C-Section □	
Date of first visit for this illness or injury	Date of next visit	Date of last visit	Frequency of visits
Is patient: Ambulatory □ Bed Confined □ House Confined □ Hospital Confined □	Has patient been admitted to hospital?		
	Confined: From:	To:	

If hospital confined, give name and address of hospital:

Have you completed claim forms regarding this patient for other insurance carriers? Yes □ No □ If yes, state date and name of insurance company:

4. Names and Addresses of Treating Physicians

Print or type name	Degree	Medical Specialty	Phone Number
Address			
City, State, Zip	SSN # or Employer's ID #		

_____ _____

Signature of Physician Date