CONNECTICUT LABORERS' HEALTH FUND
435 Captain Thomas Boulevard
West Haven, CT 06516-5896
Telephone (203) 934-7991
Toll-Free Number 1-800-922-3240

DISABILITY INCOME BENEFITS CLAIM FORM

(Return Both Copies to the Fund Office)

ALL QUESTIONS MUST BE COMPLETED BY MEMBER IN ORDER TO APPLY FOR DISABILITY INCOME BENEFITS

MEMBER'S NAME, ADDRESS AND PHONE NO.	IS THIS A NEW ADDRESS? ☐Yes ☐No	SOCIAL SECURITY NUMBER	DATE OF BIRTH	LOCAL UNION

MARITAL STATUS
☐SINGLE ☐MARRIED
☐SEPARATED ☐DIVORCED ☐WIDOWED

PLEASE PROVIDE THE FOLLOWING INFORMATION, AS IT RELATES TO THIS DISABILITY.

Type of illness or injury_____ Was this due to an injury or accident? ☐Yes ☐No

If Yes, please answer the following questions: Date of accident or injury:_____ Time:_____ ☐a.m. ☐p.m.

Where? ☐at home ☐on job ☐other If Other, explain where: _____

How did accident or injury happen: _____

Will a liability claim in connection with these charges be filed with any insurance carrier or against any individual or legal entity either through civil suit or any other means? ☐Yes ☐ No If Yes, on the reverse side of this form please provide the names and addresses of your attorney, the other party involved, and the insurance carrier.

Date last worked:_____

Number of hours worked on that date: _____

Have you returned to work? ☐Yes ☐No If Yes, date you returned to work: _____

Did you collect Unemployment or Workers' Compensation Benefits during this period? ☐Yes ☐No

If YES, please provide a statement from Unemployment or Workers' Compensation indicating the dates you received benefits.

The Fund is required to offer a Member the option to have Income Tax Withholdings made from Weekly Disability Benefits if requested. This election may be changed at any time. Please check one of the following boxes.

☐ Do not withhold taxes ☐ Withhold 20% per week

TO ALL PHYSICIANS AND OTHER HEALTH PROFESSIONALS, AND ALL HOSPITALS AND OTHER HEALTH CARE INSTITUTIONS:

You are authorized to provide the Health Fund, Aetna Life and Casualty and any independent claim administrators and consulting health professionals and utilization review organizations with whom the Health Fund or Aetna has contracted, information concerning health care, advice, treatment or supplies provided the Patient (including that relating to mental illness). This information will be used for the purpose of evaluating and administering claims for benefits. This authorization is valid for the term of coverage of the policy or contract under which a claim has been submitted. I know that I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original. **The statements contained within this claim form are true to the best of my knowledge and belief. I understand I am responsible for charges not covered by this Plan.**

Member's Signature_____ **Date** _____

TO BE COMPLETED BY PHYSICIAN

PATIENT'S NAME	DATES OF TOTAL DISABILITY FROM THROUGH	DATE PATIENT ABLE TO RETURN TO WORK

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE TO NUMBERS 1, 2, 3, ETC OR DX CODE.	IS CONDITION DUE TO A WORK-RELATED INJURY OR DISEASE? YES	NO
1.	1 ☐	☐
2.	2 ☐	☐
3.	3 ☐	☐

PROCEDURES, MEDICAL SERVICES, SUPPLIES FURNISHED

Date of Service	Place of* Service	Procedure Code ** (Identify)	Description of Service	Type of Service***	Charges	Days or Units	Diagnosis Code††

NAME OF PHYSICIAN OR SUPPLIER	Enter the taxpayer identifying number to be used for 1099 reporting purposes. You are required under authority of law to furnish your taxpayer identifying number.	TOTAL CHARGE	AMOUNT PAID	BALANCE DUE

ADDRESS ☐CHECK IF NEW	TELEPHONE NO.		PATIENT'S ACCOUNT NO.
		Physician's or Supplier's Signature Date	

*PLACE OF SERVICE CODES

1 - (H) - Inpatient Hospital
2 - (OH) - Outpatient Hospital
3 - (O) - Doctor's Office
4 - (H) - Patient's Home
5 - - Day Care Facility (PSY)
6 - - Night Care Facility (PSY)
7 - (NH) - Nursing Home
8 - (SNF) - Skilled Nursing Facility
9 - - Ambulance
0 - (OL) - Other Locations
A- (IL) - Independent Laboratory
B - - Other Medical Surgical Facility
C - (RTC) - Residential Treatment Center
D - (STF) - Specialized Treatment Facility

***TYPE OF SERVICE CODES

1 - Medical Care
2 - Surgery
3 - Consultation
4 - Diagnostic X-Ray
5 - Diagnostic Laboratory
6 - Radiation Therapy
7 - Anesthesia
8 - Assistance at Surgery
9 - Other Medical Service
0 - Blood or Packed Red Cells
A - Used DME
M - Alternate Payment for Maintenance Dialysis
Y - Second Opinion on Elective Surgery
Z - Third Opinion on Elective Surgery