North Central States Regional Council of
Carpenters' Benefit Funds
Pension • Health • Supplemental Pension • Training • LMC Trust

P.O. Box 4002 • Eau Claire, WI 54702-4002
715-835-3174 • 800-424-3405 • Fax 715-834-8061 • Claims Fax 715-835-3114

APPLICATION FOR ACCIDENT AND SICKNESS BENEFITS

TO BE COMPLETED BY PARTICIPANT

1. Participant's Full Name: _____ ID or SSN: _____

   Home Address: _____
   NUMBER AND STREET CITY STATE ZIP

   Telephone Number: (_____)_____ Date of Birth: ___/___/_____ Sex: ____ Male ____ Female

   Marital Status: ____ Single ____ Married ____ Widowed ____ Divorced ____ Legally Separated

2. Most Recent Employer: _____
3. Date Illness Began: _____
4. IF CLAIMANT WAS INJURED:
   a. When did injury occur? (Date and time) _____
   b. Where did injury occur? _____
   c. Describe how injury occurred: _____

      _____
   d. Is there a possibility that another person or company may be responsible for payment of some or all of the medical expense? ☐ Yes ☐ No If yes, indicate the name and address of the other person or company. If known, also identify the insurance carrier of the other person or company. _____

      _____

      _____
5. First Full Day Unable to Work: _____ Date Returned to Work: _____
6. Was the injury or illness caused by any employment? ☐ Yes ☐ No
7. Was, or will there be, a claim filed for this disability with a worker's compensation carrier? ☐ Yes ☐ No
8. Are you collecting or have you collected unemployment in the last three months prior to this disability?

   ☐ Yes ☐ No If yes, please indicated the dates _____ to _____

I hereby certify the statements hereon and attached are complete and accurate.

Participant's Signature: _____ ***Date:*** _____

Authorization to Release Information

I authorize any person or institution rendering care, or any person or organization in possession of insurance or other benefit information concerning me or my dependents, to furnish and disclose all known facts and data concerning my insurance coverage or medical history to the North Central States Regional Council of Carpenters; Health Fund (the "Fund") as well as to any organizations and entities retained by or authorized by the Trustees. The information obtained by use of this authorization will be used by the Fund to determine eligibility for weekly disability benefits. Any information obtained that is subject to applicable privacy laws will not be released by the Fund to any person or organization except to re-insuring companies, the Medical Information Bureau, Inc., my employer, group policyholder or other persons or organizations performing business or legal services in connection with my claim, or may be otherwise lawfully required or as I may further authorize.

I understand that:

This authorization is voluntary and I may refuse to sign it.

I may revoke this authorization at any time before its expiration date by sending a written notice to each entity that I previously authorized to disclose health information. The revocation will not have any effect on any actions that the entity took before it received the revocation notice.

I am not required to sign this authorization as a condition to receive treatment or payment for health care; enrolling in a health plan; or establishing eligibility for health benefits.

The information used or disclosed pursuant to this authorization may be redisclosed by the receiving person or organization and, upon redisclosure, may no longer be protected by federal privacy laws.

I may request to receive a copy of this authorization. I agree that a photographic copy of this authorization shall be valid as the original.

This authorization shall be valid for two and one half years from the date shown below.

- **Signature of the Patient/Participant or Patient/Participant's Representative** _____ **Date:** _____
- **Printed Name of Patient/Participant's Representative (if applicable)** _____
- **Relationship to Patient/Participant (if applicable)** _____
  Enclose documentation demonstrating authority to act as Patient/Participant's Representative.

TO BE COMPLETED BY ATTENDING PHYSICIAN

(Please be sure to date and sign.)

1. Patient's Full Name: _____ Patient's DOB: ___/___/_____
2. Date of Illness (first symptom) or injury (accident): _____
3. Date first consulted you for this condition: _____
4. Has patient ever had same or similar symptoms? ☐ Yes ☐ No If yes, please specify date: ___/___/_____
5. Diagnosis or Nature of Illness or Injury:
   a.
   b.
   c.
   d.
6. Dates of Total Disability: From _____ Through _____
7. Dates of Partial Disability: From _____ Through _____
8. Date patient is/was able to return to work: _____

Signature of Attending Physician: _____ ***Date:*** _____

Provider's EIN or Social Security Number: _____

Physician's Name: _____

Physician's Address: _____

Physician's City, State, ZIP: _____

Physician's Phone Number: _____

NOTICE OF NONDISCRIMINATION AND ACCESSIBILITY SERVICES

The North Central States Regional Council of Carpenters' Health Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Fund provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats) as well as language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages. If you need these services, please contact the Fund Office.

If you believe the Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-424-3405.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-424-3405.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-424-3405.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-424-3405.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-424-3405.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-424-3405.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-424-3405 번으로 전화해 주십시오.

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-424-3405.

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີ ພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-424-3405.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-424-3405.

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-424-3405.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-424-3405.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-424-3405 पर कॉल करें।

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-424-3405.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-424-3405.