



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 DISABILITY 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 9a. DO YOU HAVE AN ATTORNEY FOR W.C. OR ANY OTHER
 b. IF YES, HAS A WORKERS' COMPENSATION CLAIM BEEN FILED? YES NO THIRD PARTY ACCIDENT? YES NO
 IF YOUR W.C. CLAIM WAS REJECTED, ATTACH A COPY OF THE REJECTION NOTICE 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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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 <input type="checkbox"/> DATE OF OCCURRENCE _____ OCCUPATIONAL <input type="checkbox"/> YES <input type="checkbox"/> NO AUTO ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO ILLNESS <input type="checkbox"/> DATE SYMPTOMS FIRST APPEARED _____ PREGNANCY <input type="checkbox"/> YES <input type="checkbox"/> NO EDC _____ WAS SURGERY PERFORMED <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHAT TYPE OF SURGERY _____ WAS SURGERY ELECTIVE <input type="checkbox"/> YES <input type="checkbox"/> NO HOSPITALIZATION OR SUGICENTER: ADMIT DATE _____ DISCHARGE DATE _____			
PROVIDE DATES FOR EACH OF THE FOLLOWING: <i>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.</i>			
DID YOU ADVISE PATIENT TO STOP WORK? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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