HRSA-ILA Short Term Disability Application Instructions

Short term disability benefits are processed by Alicare, a third party company. The first 3 pages are Alicare forms. **Once these 3 forms are completed, fax it directly to Alicare at 914-367-4114.**

Your benefit payments are handled by HRSA-ILA. The W-4S is a form that will inform HRSA-ILA how to tax your short term disability payments. The direct deposit form will indicate which bank HRSA-ILA should use to deposit your short term disability payments. **The W-4S form and the direct deposit form is sent directly to HRSA-ILA. You may fax it to 757-423-1227 or email it to participant.services@hrsa-ila.com.

Alicare will contact you via mail to inform you of the status of your disability claim. Should you have any questions, you may contact Participant Services at 757-457-7090.

Alicare
Third Party Administration

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 DISABILILTY 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

b. IF YES, HAS A WORKERS' COMPENSATION CLAIM BEEN FILED? ❑ YES ❑ NO

IF YOUR W.C. CLAIM WAS REJECTED, ATTACH A COPY OF THE REJECTION NOTICE

9a. DO YOU HAVE AN ATTORNEY FOR W.C. OR ANY OTHER THIRD PARTY ACCIDENT? ❑ YES ❑ NO

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.

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 WELFARE FUND STD CLAIM FORM

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 ❑ DATE OF OCCURRENCE _____ OCCUPATIONAL ❑ YES ❑ NO AUTO ACCIDENT ❑ YES ❑ NO

ILLNESS ❑ DATE SYMPTOMS FIRST APPEARED _____ PREGNANCY ❑ YES ❑ NO EDC _____

WAS SURGERY PERFORMED ❑ YES ❑ NO IF YES, WHAT TYPE OF SURGERY _____ WAS SURGERY ELECTIVE ❑ YES ❑ NO

HOSPITALIZATION OR SUGICENTER: ADMIT DATE _____ DISCHARGE DATE _____

PROVIDE DATES FOR EACH OF THE FOLLOWING:

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.

	MONTH	DAY	YEAR
DID YOU ADVISE PATIENT TO STOP WORK? ❑ YES ❑ NO			
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? ❑ YES ❑ 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

Fax or mail a completed copy of this authorization to:
HRSA-ILA Welfare Fund- STD
c/o Alicare, Inc., P. O. Box 5453
White Plains, NY 10602-5453
Fax - 1-914-367-4114

Effective 10/1/2010, Alicare, Inc. is handling the Short Term Disability program provided to participating members of the HRSA-ILA Welfare Fund.

Authorization to Release My Health Care Information

Patient name: _____ Date of birth:_____

Note: The Health Insurance Portability and Accountability Act (HIPAA) requires that we obtain this authorization from you. You are not required to sign the authorization, but if you do not, Alicare, Inc. may not be able to evaluate or administer your claim for disability. Please sign and return this authorization to the address above.

I hereby give permission and authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service; health plan; rehabilitation professional; vocational evaluator; and employer that has information about my health, employment history, or other insurance claims and benefits to disclose any and all of this information to persons who administer and evaluate claims for Alicare , Inc. and Alicare Medical Management (AMM), both affiliates of Amalgamated Life Insurance Company.

I understand that any information Alicare, Inc and AMM obtains pursuant to this authorization will be used for evaluating and administering my claim(s) for disability benefits, which may include assisting me in returning to work. I further understand that the information is subject to redisclosure and might not be protected by HIPAA.

This authorization is valid for two years from the date below or the duration of my claim, whichever period is shorter. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent Alicare, Inc. and AMM have relied on the authorization prior to notice of revocation. I understand if I revoke this authorization, Alicare, Inc. may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

_____ _____/_____/_____
Print Name Social Security Number of Claimant

_____ _____
Claimant/member Signature Date Signed

I signed on behalf of the claimant as _____ (indicate relationship). If Power of Attorney Designee, Guardian, Conservator, please attach a copy of document granting authority.

Form **W-4S**

Department of the Treasury
Internal Revenue Service

Request for Federal Income Tax Withholding From Sick Pay

Give this form to the third-party payer of your sick pay.
Go to *www.irs.gov/FormW4S* for the latest information.

OMB No. 1545-0074

2024

Your first name and middle initial	Last name	**Your social security number**

Home address (number and street or rural route)

City or town, state, and ZIP code

Claim or identification number (if any)	
I request federal income tax withholding from my sick pay payments. I want the following amount to be withheld from each payment. (See **Worksheet** below.)	$

Employee's signature: Date:

---------- **Separate here and give the top part of this form to the payer. Keep the lower part for your records.** ----------

Worksheet (Keep for your records. Do not send to the IRS.)

1	Enter amount of adjusted gross income that you expect in 2024	**1**	
2	If you plan to itemize deductions on Schedule A (Form 1040), enter the estimated total of your deductions. See Pub. 505 for details. If you don't plan to itemize deductions, enter the standard deduction. (See the instructions on page 2 for the standard deduction amount, including additional standard deductions for age and blindness.) **Note:** There is no deduction for personal exemptions for 2024	**2**	
3	Subtract line 2 from line 1	**3**	
4	Tax. Figure your tax on line 3 by using the **2024** Tax Rate Schedule X, Y-1, Y-2, or Z on page 2. **Do not** use any tax tables, worksheets, or schedules in the 2023 Instructions for Form 1040	**4**	
5	Credits (child tax and higher education credits, credit for child and dependent care expenses, etc.) . .	**5**	
6	Subtract line 5 from line 4	**6**	
7	Estimated federal income tax withheld or to be withheld from other sources (including amounts withheld due to a prior Form W-4S) during 2024 or paid or to be paid with 2024 estimated tax payments . . .	**7**	
8	Subtract line 7 from line 6	**8**	
9	Enter the number of sick pay payments you expect to receive this year to which this Form W-4S will apply	**9**	
10	Divide line 8 by line 9. Round to the nearest dollar. This is the amount that should be withheld from each sick pay payment. Be sure it meets the requirements for the amount that should be withheld, as explained under *Amount to be withheld* below. If it does, enter this amount on Form W-4S above . .	**10**	

General Instructions

Purpose of form. Give this form to the third-party payer of your sick pay, such as an insurance company, if you want federal income tax withheld from the payments. You aren't required to have federal income tax withheld from sick pay paid by a third party. However, if you choose to request such withholding, Internal Revenue Code sections 3402(o) and 6109 and their regulations require you to provide the information requested on this form. Don't use this form if your employer (or its agent) makes the payments because employers are already required to withhold federal income tax from sick pay.

Note: If you receive sick pay under a collective bargaining agreement, see your union representative or employer.

Definition. Sick pay is a payment that you receive:

- Under a plan to which your employer is a party, and
- In place of wages for any period when you're temporarily absent from work because of your sickness or injury.

Amount to be withheld. Enter on this form the amount that you want withheld from each payment. The amount that you enter:

- Must be in whole dollars (for example, $35, not $34.50).
- Must be at least $4 per day, $20 per week, or $88 per month based on your payroll period.
- Must not reduce the net amount of each sick pay payment that you receive to less than $10.

For payments larger or smaller than a regular full payment of sick pay, the amount withheld will be in the same proportion as your regular withholding from sick pay. For example, if your regular full payment of $100 a week normally has $25 (25%) withheld, then $20 (25%) will be withheld from a partial payment of $80.

Caution: You may be subject to a penalty if your tax payments during the year aren't at least 90% of the tax shown on your tax return. For exceptions and details, see Pub. 505, Tax Withholding and Estimated Tax. You may pay tax during the year through withholding or estimated tax payments or both. To avoid a penalty, make sure that you have enough tax withheld or make estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. You may estimate your federal income tax liability by using the worksheet above.

Sign this form. Form W-4S **is not** valid unless you sign it.

Statement of income tax withheld. After the end of the year, you'll receive a Form W-2, Wage and Tax Statement, reporting the taxable sick pay paid and federal income tax withheld during the year. These amounts are reported to the IRS.

Changing your withholding. Form W-4S remains in effect until you change or revoke it. You may do this by giving a new Form W-4S or a written notice to the payer of your sick pay. To revoke your previous Form W-4S, complete a new Form W-4S and write "Revoked" in the money amount box, sign it, and give it to the payer.

(continued on back)

Specific Instructions for Worksheet

You may use the worksheet on page 1 to estimate the amount of federal income tax that you want withheld from each sick pay payment. Use your tax return for last year and the worksheet as a basis for estimating your tax, tax credits, and withholding for this year.

You may not want to use Form W-4S if you already have your total tax covered by estimated tax payments or other withholding.

If you expect to file a joint return, be sure to include the income, deductions, credits, and payments of both yourself and your spouse in figuring the amount you want withheld.

Caution: If any of the amounts on the worksheet change after you give Form W-4S to the payer, you should use a new Form W-4S to request a change in the amount withheld.

Line 2—Deductions

Itemized deductions. Itemized deductions include qualifying home mortgage interest, charitable contributions, state and local taxes (up to $10,000), and medical expenses in excess of 7.5% of your adjusted gross income. See Pub. 505 for details.

Standard deduction. For 2024, the standard deduction amounts are:

Filing Status	Standard Deduction
Married filing jointly or qualifying surviving spouse	$29,200*
Head of household	$21,900*
Single or Married filing separately	$14,600*

*If you're age 65 or older or blind, add to the standard deduction amount the additional amount that applies to you as shown in the next paragraph. If you can be claimed as a dependent on another person's return, see *Limited standard deduction for dependents*, later.

Additional standard deduction for the elderly or blind. An additional standard deduction of $1,550 is allowed for a married individual (filing jointly or separately) or a qualifying surviving spouse who is 65 or older or blind, $3,100 if 65 or older **and** blind. If both spouses are 65 or older or blind, an additional $3,100 is allowed on a joint return. If both spouses are 65 or older **and** blind, an additional $6,200 is allowed on a joint return. Additional standard deductions are also allowed on your separate return for your spouse who is 65 or older and/or blind if your spouse has no gross income and can't be claimed as a dependent by another taxpayer. An additional $1,950 is allowed for an unmarried individual (single or head of household) who is 65 or older or blind, $3,900 if 65 or older **and** blind. See the 2024 Estimated Tax Worksheet—Line 2 Standard Deduction Worksheet in Pub. 505.

Limited standard deduction for dependents. If you are a dependent of another person, your standard deduction is the greater of (a) $1,300 or (b) your earned income plus $450 (up to the regular standard deduction for your filing status). If you're 65 or older or blind, see Pub. 505 for additional amounts that you may claim.

Certain individuals not eligible for standard deduction. For the following individuals, the standard deduction is zero.

- A married individual filing a separate return if either spouse itemizes deductions.
- A nonresident alien individual. For exceptions, see Pub. 519, U.S. Tax Guide for Aliens.
- An individual filing a return for a period of less than 12 months because of a change in his or her annual accounting period.

Line 5—Credits

Include on this line any tax credits that you're entitled to claim, such as the child tax credit and credit for other dependents, higher education credits, credit for child and dependent care expenses, earned income credit, or credit for the elderly or the disabled. See the Tax Credits table in Pub. 505 for more information.

Line 7—Tax Withholding and Estimated Tax

Enter the federal income tax that you expect will be withheld this year on income other than sick pay and any payments made or to be made with 2024 estimated tax payments. Include any federal income tax already withheld or to be withheld from wages and pensions.

2024 Tax Rate Schedules

Schedule X—Single

If line 3 is: Over—	But not over—	The tax is:	of the amount over—
$0	$11,600	**$0 + 10%**	**$0**
11,600	47,150	**1,160 + 12%**	**11,600**
47,150	100,525	**5,426 + 22%**	**47,150**
100,525	191,950	**17,168.50 + 24%**	**100,525**
191,950	243,725	**39,110.50 + 32%**	**191,950**
243,725	609,350	**55,678.50 + 35%**	**243,725**
609,350	and greater	**183,647.25 + 37%**	**609,350**

Schedule Z—Head of household

If line 3 is: Over—	But not over—	The tax is:	of the amount over—
$0	$16,550	**$0 + 10%**	**$0**
16,550	63,100	**1,655 + 12%**	**16,550**
63,100	100,500	**7,241 + 22%**	**63,100**
100,500	191,950	**15,469 + 24%**	**100,500**
191,950	243,700	**37,417 + 32%**	**191,950**
243,700	609,350	**53,977 + 35%**	**243,700**
609,350	and greater	**181,954.50 + 37%**	**609,350**

Schedule Y-1—Married filing jointly or Qualifying surviving spouse

If line 3 is: Over—	But not over—	The tax is:	of the amount over—
$0	$23,200	**$0 + 10%**	**$0**
23,200	94,300	**2,320 + 12%**	**23,200**
94,300	201,050	**10,852 + 22%**	**94,300**
201,050	383,900	**34,337 + 24%**	**201,050**
383,900	487,450	**78,221 + 32%**	**383,900**
487,450	731,200	**111,357 + 35%**	**487,450**
731,200	and greater	**196,669.50 + 37%**	**731,200**

Schedule Y-2—Married filing separately

If line 3 is: Over—	But not over—	The tax is:	of the amount over—
$0	$11,600	**$0 + 10%**	**$0**
11,600	47,150	**1,160 + 12%**	**11,600**
47,150	100,525	**5,426 + 22%**	**47,150**
100,525	191,950	**17,168.50 + 24%**	**100,525**
191,950	243,725	**39,110.50 + 32%**	**191,950**
243,725	365,600	**55,678.50 + 35%**	**243,725**
365,600	and greater	**98,334.75 + 37%**	**365,600**

Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

HRSA-ILA

Short Term Disability (STD) Direct Deposit Request

Use this form to start, change, or cancel direct deposit of your STD benefit. I understand that if I do not timely file a new direct deposit authorization form, my STD checks will be automatically mailed to my permanent home address currently on file at the Fund Office. **Changes to your STD Direct Deposit information can be processed by the Funds Office up to 12:00 p.m. on Thursday of the week benefits are paid out.**

Member Information:

Port No: _____ Member Name: _____

SS# (last 4) XXX-XX- | | | | |

E-Mail Address: _____ Phone: _____

I authorize HRSA-ILA and my financial institution to transfer into my account:

Financial Institution: _____

Type of Account: Checking: _____ Savings: _____

Attach a voided check **here** or have your financial institution provide a bank letter confirming your account information for direct deposit.

- **Direct deposit request will not be accepted without either a check or bank letter**
- Starter checks for direct deposit not accepted without account holder's name on it
- Direct deposit will not be accepted unless the payee is the account holder or joint account holder
- Do not attach a deposit slip

I acknowledge that HRSA-ILA has no control over the accessibility of funds in my account after the direct deposit is made.

Payee Signature: _____ Date: _____