LiUNA!
WISCONSIN LABORERS' HEALTH FUND
Feel the Power

4633 LIUNA WAY, SUITE 201
DEFOREST, WI 53532-2510
TELEPHONE: 608-846-1742
TOLL FREE: 800-397-3373

PROOF OF DISABLED DEPENDENT FORM

SECTION 1 – TO BE COMPLETED BY MEMBER

Member's Full Name: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone #: _____ Relationship to Dependent: _____

Incapacitated Dependent's Name: _____ ☐ Male ☐ Female

Dependent's Date of Birth: _____ Dependent's Marital Status: ☐ S ☐ M ☐ D ☐ W

Dependent's SSN: _____ Dependent's Medicare HICN: _____

Dependent's Age When Disability Occurred: _____ Describe Disability: _____

Is dependent permanently residing in your household? ..... ☐ YES ☐ NO

If NO, why not? _____

Is dependent employed for wages? ..... ☐ YES ☐ NO

If YES, employer's name: _____ # of hours per month _____

Is dependent attending school? ..... ☐ YES ☐ NO If Yes, ☐ Full-Time ☐ Part-Time

Is dependent capable of self-support? ..... ☐ YES ☐ NO

Is dependent listed as your dependent on your last income tax return? .. ☐ YES ☐ NO

Is dependent covered under any other hospital or medical coverage? .... ☐ YES ☐ NO

If YES: Insurance Company name: _____ Policy #: _____

SECTION 2 – PARENT OR LEGAL GUARDIAN SIGNATURE

I hereby certify that all information provided is correct to the best of my knowledge and that this dependent is incapable of self-support and remains dependent upon me for support and maintenance. I understand that it is my responsibility to notify the Wisconsin Laborers' Health Fund within 31 days of any changes in eligibility of this dependent and that a review status to verify continued eligibility may be requested at any time. Failure to notify of changes in eligibility status may result in penalties and repayment of benefits paid on behalf of the ineligible dependent.

Participants Signature: _____ Date: _____

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SECTION 3 – AUTHORIZATION TO RELEASE CLAIM INFORMATION

I hereby authorize _____ to disclose personal health
(Physician, hospital or provider of health care services)

information relating to diagnosis or rendered treatment for _____ to the Wisconsin Laborers' Health
(Patient's name)

Fund. I authorize this disclosure for the purpose of determining if the named dependent meets the qualification for eligibility under the incapacitated dependents classification. This authorization will be valid for the duration of my claim.

CONFIRMATION OF UNDERSTANDING

I understand that I have the right to revoke this authorization at anytime. I also understand that my revocation of this authorization must be in writing. To obtain a copy of an Authorization Revocation form I may contact the Plan Office at the address and/or telephone number at the top of this form. I am aware that my revocation will not apply to uses and/or disclosures of my personal health information that has already made in reliance upon this authorization.

I understand that if I sign this authorization, I must be provided a signed copy of it. I understand that I am under no obligation to sign this form, and that Wisconsin Laborers' Health Fund will not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

By signing this form, I am confirming that it accurately reflects my wishes.

Signature of Patient or Personal Representative: _____ Date: _____

If signed by a personal representative:

Printed name of Personal Representative: _____

Relationship to patient or nature of authority: _____

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SECTION 4 – PROOF OF INCAPAITATED DEPENDENT FORM TO BE COMPLETED BY ATTENDING PHYSICIAN

Note: any fee for the completion of this form is the responsibility of the member.

Patient's Name: _____ Date of Birth: _____

Date incapacity began: _____ Date of last exam: _____ Frequency of visits: _____

Diagnosis: _____

_____

Present treatment plan: _____

Extent of Disability

Is patient incapable of full-time student status? ..... ☐ YES ☐ NO

Will patient always be dependent upon someone else for support? ..... ☐ YES ☐ NO

Is patient incapable of support himself/herself through gainful employment? ... ☐ YES ☐ NO

Has such disability existed continuously before patient attained age 19? ..... ☐ YES ☐ NO

In your professional opinion would you consider this individual to be permanently and totally incapacitated due to a physical or mental impairment that is expected to result in heath or last for a continuous period of 12 months or more? ..... ☐ YES ☐ NO

Physician's Signature: _____ Date: _____ EIN/SSN: _____

Printed Physician's Name: _____ Address: _____

City _____

State: _____ Zip: _____

Phone Number: _____