WISCONSIN LABORERS' HEALTH FUND
4633 LIUNA WAY, SUITE 201 DE FOREST, WI 53532-2510
TELEPHONE: 608-842- 9101 TOLL FREE: 800-397-3373
WEBSITE: WWW.WILBENEFITS.COM

DISABILITY STATEMENT OF CLAIM

FOR ACCIDENT AND SICKNESS BENEFITS

INSTRUCTIONS:
This form must be submitted by the individual claimant to the office of the Claim Administrator properly and fully completed and signed by claimant and the attending physician to be considered for disability benefits and/or eligibility credit hours through the fund. Visit www.wilbenefits.com for a breakdown of these benefits located under Health Fund/Summary of Benefits.

To Be Completed By Member

Member's Full Name (*First, Middle Initial, Last*): _____

Member ID: _____

Member SSN: _____

Address (*Street, City, State, and Zip Code*): _____

Birthdate: _____ /_____ / _____

Phone Number: (_____) _____

Is member claiming or receiving workmen's compensation benefits? ☐ Yes ☐ No *Note: If yes, you will only be eligible for possible credit hours through the eligibility department*	***If "Yes" to previous question*, What is the present status of the compensation claim?**
First full day unable to work: _____/_____/_____	**Describe Illness or Injury**
Date of first medical attention for this condition: _____/_____/_____	
Are you totally disabled by this illness or injury? ☐ Yes ☐ No	**Are you now unable to physically engage in any work, occupation or business?** ☐ Yes ☐ No
Have you returned to work? ☐ Yes *Provide date returned to work*: _____/_____/_____ ☐ No *Date expected to return to work:* _____/_____/_____ **If released to light-duty work, please forward written confirmation from employer or union if no light-duty work is available.**	
Name of Employer: _____	**Telephone No.:** _____

I HEREBY AUTHORIZE the physician to release information requested with respect to this claim. I certify that the information furnished by me in support of this claim is true and correct. I know it is unlawful to fill out this form with facts that I know are false or to leave out facts I know are important.

Signature of Employee: _____ **Date Signed:** ____ / _____ / _____

To Be Completed By Physician

Physician's Name: _____ **Specialty**_____

Office Address (Street, City, State, Zip Code) _____

Telephone: _____ **Fax Number:** _____ **Tax ID Number:** _____
(Must be furnished under authority of law)

Is this person, listed above, under your professional care at present? ☐ Yes ☐ No			
Nature of Sickness or Injury. Describe Complications, If Any:			
Did this sickness or injury arise out of patient's employment? ☐ Yes ☐ No **If "Yes", explain:**			
The patient has been continuously disabled (unable to work): **From:** _____/_____/_____ **Through:** _____/_____/_____		***If still disabled*, when should patient be able to return to work?** ***Please project a date, if possible.*** _____/_____/_____	
Date Of First Treatment _____/_____/_____	**Date of Most Recent Treatment** _____/_____/_____	**Frequency of Treatment**	**Next Appointment Date** _____/_____/_____
Additional Comments:			

Acknowledgement – I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief.

Physician's Signature: _____ **Date:** _____/_____/_____

Weekly Accident and Sickness Benefit – Disability Payments and Eligibility Credit Hours Must be Returned One of The Following Ways:

Mailed:
WI Laborers' Health Fund
Attn: Disability Benefits -Claims
4633 Liuna Way Ste 201
Deforest, WI 53532

Faxed:
(608) 846-3224
Attention: Claims Disability Form

Emailed:
wlclaims@benesys.com
Subject: Disability Claim Form

Weekly Accident and Sickness Benefit Information

The Weekly Accident and Sickness Benefit is payable if you are disabled due to an Injury or Sickness that is not work-related or covered by workers' compensation laws, and you cannot work as a result. You must also be under the care of a Physician to receive this benefit.

If eligible:

- you will receive $300 each week under the Weekly Accident and Sickness Benefit.
- For partial weeks of disability, you will be paid a daily rate of one-seventh of $300.
- Benefits are paid for up to 19 weeks for any one period of Certified Disability.
- A second Certified Disability will be considered a new period of disability if the Certified Disabilities are:
  - Unrelated and you return to active full-time Covered Work for at least one full day between Certified Disabilities; or
  - Related and you return to full-time Covered Work, or you are ready and available for Covered Work, for at least two continuous weeks between periods of disability.

When Benefits Begin

Weekly Accident and Sickness Benefits begin on the:

- First day of a Certified Disability due to an accidental bodily Injury; or
- Eighth day of a Certified Disability due to Sickness.

However, you will be paid retroactively to the first day of a Certified Disability due to Sickness if you remain ill and are unable to work past the eight-day waiting period.

No disability will be considered as beginning more than three days prior to the first visit to a Physician or Surgeon.

Non-Work Hours

During your Certified Disability, you will be credited with 30 disability hours for each full week of disability, up to an annual maximum of 525 hours. In no event will you receive more than 525 disability hours in any 12 consecutive-month period, regardless of the number of periods of disability you have. Credit hours will be applied toward continuing eligibility requirements; however, self-contributions may still be required.

Maternity Benefit

The Plan offers an $800 weekly benefit (payable at birth) in connection with a live birth for active eligible female employees. The benefit is payable for six (6) weeks per live birth for a traditional delivery, and eight (8) weeks for a cesarean section delivery.

Limitations

Weekly Accident and Sickness Benefits will not be paid to:

- Participants covered under the Bare Bones Plan;
- Salaried Employees receiving salary continuation from their Employer while disabled; or
- Retirees.

The Weekly Accident and Sickness Benefit is subject to federal and state income taxes as well as Social Security taxes. The necessary deductions will be taken before you receive your check. The Fund Office will send you a W-2 Form after the end of the year indicating the amount you received.

For more information about disability payments and process, please call: 608-842-9101

Workmen's Compensation Benefit – Eligibility Credit Hours Only Form Must Be Returned One of The Following Ways:

Mailed:
Wisconsin Laborers' Health Fund
4633 Liuna Way Ste 201
Deforest, WI 53532

Faxed:
(608) 846-3192
Attention: Eligibility Credit Hours

Email:
wleligibility@benesys.com
Subject: Eligibility Credit Hours Form

What is Workmen's Compensation?

Workers' compensation is a system that exists in all states to protect workers who become hurt on the job or contract an illness as a result of their job. If you think this is you please contact your employer or union rep for more information.

If I am awarded Workmen's Compensation, do I still have any benefits for disability through the Wisconsin Laborers'?

Yes! If you cannot perform Covered Work because of a Certified Disability, you will be credited with disability hours to maintain your eligibility. A Certified Disability is a disability for which you are receiving Weekly Accident and Sickness Benefits through the Fund or weekly workers' compensation benefits. You will be credited with 30 disability hours for each full week of a Certified Disability.

Disability hours are limited to 525 hours within any continuous 12-month period. For hours to be credited, you must notify the Fund Office and apply for benefits. Note: Participants covered under the Bare Bones Plan are not eligible for credit hours. If your Certified Disability lasts more than 12 months, you may earn additional disability hours during the second and each following year by submitting an application for disability hours. You must be eligible for coverage at the time you apply for additional disability hours; disability hours cannot be used to earn eligibility when a lapse in coverage has occurred. In addition, in subsequent years, disability hours will continue to be limited to 525 hours in any 12-consecutive month period.

For more information about eligibility credit hours and process, please call: 608-842-9094