



# Heat and Frost Insulators Local 34 Health & Welfare Trust

3001 Metro Drive, Suite 500 • Bloomington, MN 55425 • P: 952•851•5948 • F: 952•854•1632

## DISABILITY / MN PAID LEAVE

**INSTRUCTIONS:** THIS FORM IS TO BE COMPLETED BY THE MEMBER TO APPLY FOR DOLLAR BANK CREDITS AND/OR DISABILITY BENEFITS. YOU MUST APPLY FOR MN PAID LEAVE BEFORE COMPLETING THIS FORM. **NO BENEFITS CAN BE PAID UNLESS THIS FORM IS COMPLETED IN ITS ENTIRETY**

**MEMBER COMPLETES THIS SECTION:**

Name of Member		Home Phone	
Date of Birth	Social Security Number	Occupation	
Employer			
Home Address	City	State	Zip Code
If claims is for member's disability, show date last worked:		Date resumed work:	

**MN PAID LEAVE:**

**YOU MAY BE ELIGIBLE TO RECEIVE DOLLAR BANK CREDITS FOR UP TO 6 MONTHS AT NO COST WHILE ON MN PAID FAMILY LEAVE**  
EFFECTIVE DATE OF MN PAID FAMILY LEAVE \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**IF YOU HAVE NOT APPLIED FOR MN PAID FAMILY LEAVE YOU ARE INELIGIBLE FOR DISABILITY BENEFITS AND DOLLAR BANK ELIGIBILITY CREDITS**

**REASON FOR MN PAID LEAVE**

**FAMILY LEAVE** (Bonding, Caring, Military or Safety Leave)

Skip to signature for application to receive up to 6 months of dollar bank credits while on MN PAID LEAVE.

**YOU MUST INCLUDE A COPY OF YOUR MN PAID LEAVE STATEMENTS WITH THIS APPLICATION.**

**MEDICAL LEAVE FOR MYSELF**

**Please include your MN PAID LEAVE DOCUMENTATION and complete the all the information below including the physician's statement to apply for up to 6 months of dollar bank eligibility credits and disability benefits. Please note that you are not eligible for disability benefit unless MN PAID LEAVE is exhausted.**

**IF YOU CHECKED "MEDICAL LEAVE FOR MYSELF" PLEASE COMPLETE THIS SECTION:**

Nature of Sickness or Injury:	Date Accident Occurred or Sickness Began:	Date First Treated:
If Hospitalized, Name of Hospital:	Date Admitted:	Date Discharged:
Did someone intentionally cause this injury? <input type="checkbox"/> YES <input type="checkbox"/> NO	Was injury due to an accident? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Did the accident happen on your property? <input type="checkbox"/> YES <input type="checkbox"/> NO If no, address where accident occurred:		
Was this due to an auto accident? <input type="checkbox"/> YES <input type="checkbox"/> NO	Did injury or illness occur in the course of employment? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Have you filed this claim under Workmen's Compensation? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Have you started a lawsuit related in any way to this injury/illness? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Have you received any settlement, payment, recovery of benefits, including insurance company policy, related in any way to this injury/illness? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Have you hired an attorney to represent you regarding this claim? <input type="checkbox"/> YES <input type="checkbox"/> NO		

**I hereby make claim for benefits and certify that the above statements are true and correct to the best of my knowledge and belief. I authorize the above named institution or physcian to release information concerning my enrollment, related records and medical records to the Heat and Frost Insulators Local 34 Health & Welfare Trust.**

Insured Member's Signature

Date

\_\_\_\_\_

**INSTRUCTIONS:**

**ATTENDING PHYSICIAN'S STATEMENT**

This form does not have to be completed, if you can furnish the Administrator with a complete itemized and coded statement of services from the doctor. If you do not have a complete itemized and coded statement, your physician may use this form to report his/her services and charges.

**DISABILITY**

To collect disability benefits, your physician must complete questions, 1, 2, 4, 5, 7, 8, 9 and sign and date this form.

**ATTENDING PHYSICIAN'S STATEMENT:**

1. Diagnosis and concurrent conditions (if diagnosis code other than ICDA used, give name).

2. Is the condition due to injury or sickness arising out of patient's employment?	Is condition due to pregnancy? If yes, approximate date pregnancy commenced. <input type="checkbox"/> YES <input type="checkbox"/> NO
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3. Report of services (or attach itemized bill. If previous form submitted to this carrier, you need show only dates and services since last report).

Date of Services	Place of Services	Description of Surgical or Medical Services Rendered	Procedure code - If used If code other than CPT used, give name	Charges	Office Use Only

+O = Doctor's Office H = Patient's Home NH = Nursing Home ICDA = International Classification of Diseases CPT = Current Procedure Terminology (current location)	IH = Inpatient Hospital OH = Outpatient Hospital OL = Other Location	Total Charges \$ _____
		Amount Paid \$ _____
		Balance Due \$ _____

4. Date symptoms first appeared or accident happened.	5. Date patient first consulted you for this condition.	6. Has patient ever had same or similar condition? if yes, when and describe. <input type="checkbox"/> YES <input type="checkbox"/> NO
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7. Is patient still under your care for this condition? <input type="checkbox"/> YES <input type="checkbox"/> NO	8. Patient was continuously totally disabled (unable to work). From: _____ Thru: _____	9. Date patient should be able to return to work, if still disabled.
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10. Does patient have other health coverage? If yes, please identify <input type="checkbox"/> YES <input type="checkbox"/> NO	Taxpayers identification number:
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Print Physician's Name	Physician's Signature	Degree	Date
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Street address	Telephone
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City	Providence	State	Zip Code
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**MEMBERS ASSIGNMENT (PLEASE READ BEFORE SIGNING)**

**To be completed and signed by the Member if direct payment by fund to surgeon or physician is desired.** (This assignment may not be honored if signed by a dependent or person other than the Insured Member).

**I hereby authorize the Heat and Frost Insulators Local 34 Health & Welfare Trust to pay directly to the above named hospital or physician the Medical or Surgical Expense Benefits to which I am entitled under the terms of the Group Policy.**

Insured Member's Signature \_\_\_\_\_ Date \_\_\_\_\_