APPLICATION FOR SICK LIST BENEFIT

Local 705 I. B. T. Health & Welfare Fund
1645 W. Jackson Blvd., Suite 700
Chicago, IL 60612
(312) 738-2811
*****(312) 376-4003 FAX*****

You must complete this form in its entirety and return it to the Fund Office.

Name ______________________ BCBS ID # or SSN ______________________

Phone ______________________ Alternate Phone ______________________

Address ______________________ City/State/Zip ______________________

Employer ______________________ Employer's Phone ______________________

Nature of Illness or Injury in Detail ______________________

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I am applying for Sick List Benefits for the period beginning ______________________

When did you become wholly unable to work? (Date and Time) ______________________

Have you been continually disabled since you became unable to work? ☐ YES ☐ NO

If yes, approximately when do you feel you will be able to return to work? ______________________

Did disability result from employment? ☐ YES ☐ NO

Are you on lay-off? ☐ YES ☐ NO If yes, indicate start date ______________________

Are you on FMLA? ☐ YES ☐ NO If yes, indicate start date ______________________

Are you entitled to any sick/vacation pay for this time period of disability? ☐ YES ☐ NO

If yes, indicate the dates ______________________

Please provide your treating physician's information so that we may have them certify your disability.

Physician's Name ______________________

Address ______________________ City/State/Zip ______________________

Phone ______________________ **Physician's Fax Number (Required)** ______________________

Authorization For Release of Information: In order to process a claim for benefit, I authorize any physician, hospital, or other medical provider to release to the Local 705 IBT Health & Welfare Fund any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A copy of this authorization shall be considered as effective and valid as the original.

Date ______________________ Participant's Signature ______________________