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) 376-4002 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 _____

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 _____