IMPACT Off-the-Job Accident Plan

WEEKLY TIME LOSS CLAIM FORM

625 Enterprise Drive • Oak Brook, IL 60523 • Phone/Fax 630-828-7000

Administered by Benefits Management Group, Inc. (BMGi)

☐ Initial request for benefits ☐ Supplemental information on active disability claim ☐ Check here if your address is new

SECTION A	TO BE COMPLETED BY THE IRONWORKER			
IRONWORKER NAME	☐ MALE ☐ FEMALE	DATE OF BIRTH	ID NO.	SOCIAL SECURITY NO.
HOME ADDRESS CITY STATE ZIP				PHONE NO.
EMAIL ADDRESS				

DESCRIPTION OF ACCIDENT OR INJURY _____

DATE OF ACCIDENT OR DATE OF INJURY _____ WERE YOU AT WORK? ☐YES ☐NO

HAVE YOU OR WILL YOU FILE FOR WORKERS' COMPENSATION BENEFITS? ☐YES ☐NO

WERE YOU UNDER THE INFLUENCE OF INTOXICANTS WHILE OPERATING A VEHICLE? ☐YES ☐NO

NAME OF YOUR DOCTOR _____

NAME AND ADDRESS OF HOSPITAL _____

DATE ENTERED HOSPITAL _____ DATE DISCHARGED _____

ARE YOU RETIRED? ☐YES ☐NO IF NO, ANTICIPATED DATE OF RETIREMENT: _____ IF YES, WHEN: _____

ARE YOU RECEIVING OR ENTITLED TO RECEIVE UNEMPLOYMENT BENEFITS? ☐YES ☐NO

IF YES, LIST YOUR LAST DATE OF WEEKLY UNEMPLOYMENT BENEFITS? _____ IF NO, WILL FILE A CLAIM FOR UNEMPLOYMENT BENEFITS? ☐YES ☐NO

"I hereby authorize any Dentist, Physician, Hospital, Pharmacy, Insurance Company, Employer, Health Plan Administrator or Local Union Organization to release any information regarding the medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable including disability or employment related information concerning this claim to Benefits Management Group, Inc. or its authorized agent for the purpose of validating and determining benefits payable in connection with this claim. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request."

SIGN HERE► _____ _____

IRONWORKER SIGNATURE DATE SIGNED

SECTION B	TO BE COMPLETED BY THE LOCAL UNION	
EMPLOYER:	LOCAL UNION NO.	RAB:
JOB CLASSIFICATION: ☐APPRENTICE ☐JOURNEYMAN ☐FOREMAN ☐GENERAL FOREMAN ☐OTHER _____		GROSS BASIC WEEKLY EARNINGS: $_____
DATE IRONWORKER LAST WORKED:	DATE IRONWORKER RETURNED TO WORK, IF APPLICABLE:	
WAS THE IRONWORKER A MEMBER ON THE DATE OF INJURY? ☐YES ☐NO		

SIGN HERE► _____ _____

AUTHORIZED REPRESENTATIVE DATE SIGNED

SECTION C	TO BE COMPLETED BY ATTENDING PHYSICIAN			
PATIENT'S NAME:			AGE:	
DIAGNOSIS (ICD10):		IF HOSPITALIZED FOR THIS CONDITION GIVE DATE OF ADMIT:		
IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? ☐ YES ☐ NO		PREGNANCY? IF YES, APPROXIMATE DATE OF DELIVERY: ☐ YES ☐ NO		
IS CONDITION RESULT OF INJURY/ACCIDENT OR SICKNESS/ILLNESS? ☐ YES ☐ NO		IF YES: ☐ INJURY/ACCIDENT ☐SICKNESS/ILLNESS		
DATE SYMPTOMS FIRST APPEARED OR INJURY/ACCIDENT HAPPENED:		DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION:		
HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? ☐ YES ☐ NO IF "YES", WHEN & DESCRIBE:		IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐YES ☐NO		
PATIENT WAS CONTINUOUSLY UNABLE TO WORK FROM: TO:		LAST DATE WORKED:		
IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK:		DATE IRONWORKER RETURNED TO WORK:		
DATE	PHYSICIAN'S NAME (PRINT)	SIGNATURE X	DEGREE	PHONE
STREET ADDRESS		CITY – STATE – ZIP		

SEE REVERSE SIDE FOR FILING INSTRUCTIONS

PROCEDURE FOR FILING A CLAIM

- ☐ **Review your claim form carefully**
  - Be sure all information outlined in Section A, B, and C is complete

- ☐ **Sign your claim form**
  - The form must be signed by the ironworker, the Local, and the attending physician

- ☐ **Verify that your claim form was submitted**
  - Be sure the physician or the Local submits the completed claim form if they are sending it on your behalf

- ☐ **Verify your contact information**
  - Ensure your address, email address, and phone number are current and legible

- ☐ **Check your mail**
  - BMGi may send you a form requesting additional information
  - Be sure to promptly complete and return all paperwork BMGi sends to you

- ☐ **If BMGi notifies you that information was requested from the doctor, contact them**
  - Be sure your physician's office promptly completes and returns requested information to BMGi

- ☐ **Apply for Local Union, City, State or Federal government benefits, if applicable**
  - BMGi will need this information in order to calculate benefit offsets

- ☐ **BMGI will ask your health plan to verify eligibility on the date of your injury**
  - Confirm you are eligible under your health plan during the month of your off-the-job injury

- ☐ **Submit completed claim form to:**

Email: IMPACT@bmgiweb.com

Mail: IMPACT Off-the-Job Accident Plan
625 Enterprise Drive
Oak Brook, IL 60523

Phone/Fax: 630-828-7000

Questions? Call 630-828-7000