IMPACT Off-the-Job Accident Plan

WEEKLY TIME LOSS CLAIM FORM

625 Enterprise Drive • Oak Brook, IL 60523 • Phone 630-828-7000
Administered by Benefits Management Group, Inc. (BMGi)

RETURN COMPLETED FORM
IMPACT@bmgiweb.com or
Fax or Text 630-828-7000

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

SECTION A – PLEASE PRINT LEGIBLY — TO BE COMPLETED BY THE IRONWORKER

IRONWORKER NAME	SOCIAL SECURITY NO. - -	BOOK NO.	DATE OF BIRTH	GENDER
HOME ADDRESS INCLUDING CITY – STATE - ZIP			LOCAL UNION NO.	
MOBILE PHONE NO.	EMAIL ADDRESS		ARE YOU RETIRED	

DATE OF ACCIDENT/INJURY ____________ WERE YOU INTOXICATED WHEN THE INCIDENT OCCURRED?

FULL DETAILS ON HOW AND WHERE THE INCIDENT HAPPENED ____________

WERE YOU AT WORK WHEN INCIDENT OCCURRED? HAVE YOU FILED FOR WORKERS' COMPENSATION BENEFITS?

HAVE YOU FILED FOR UNEMPLOYMENT BENEFITS? ARE YOU CURRENTLY RECEIVING UNEMPLOYMENT BENEFITS?

WHAT IS THE DATE AND GROSS AMOUNT OF YOUR LATEST UNEMPLOYMENT CHECK ____________

NAME OF YOUR DOCTOR ____________ DOCTOR'S PHONE NO. ____________

NAME AND ADDRESS OF HOSPITAL ____________

DATE ENTERED HOSPITAL ____________ DATE DISCHARGED ____________

"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 – PLEASE PRINT LEGIBLY — TO BE COMPLETED BY ATTENDING PHYSICIAN

PATIENT'S NAME		AGE	IS PATIENT PREGNANT?
DIAGNOSIS (ICD10) CODES			IF HOSPITALIZED, DATE OF ADMISSION
IS CONDITION RELATED TO EMPLOYMENT?		IS CONDITION DUE TO AN ACCIDENT?	
PLEASE DESCRIBE ACCIDENT/INJURY:			
DATE FIRST CONSULTED FOR THIS CONDITION:		IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? NEXT APPOINTMENT DATE: ____________	
IS PATIENT **UNABLE** TO PERFORM THE DUTIES OF AN IRONWORKER WITH THIS CONDITION?			
PATIENT IS CONTINUOUSLY UNABLE TO WORK FROM: ____________ TO: ____________			
DATE	PHYSICIAN'S NAME (PLEASE PRINT)	SIGNATURE X	DEGREE
STREET ADDRESS INCLUDING CITY – STATE – ZIP			PHONE

PHYSICIAN, PLEASE COMPLETE THIS SECTION AT FOLLOW UP APPOINTMENT
DATE OF FOLLOWUP: ____________

IF PATIENT IS RELEASED TO RETURN TO WORK, PLEASE PROVIDE THE DATE S/HE MAY RETURN TO WORK:	IF PATIENT IS **NOT** RELEASED TO RETURN TO WORK, PLEASE PROVIDE THE DATE OF THE NEXT APPOINTMENT:
PHYSICIAN SIGNATURE	

SECTION C – PLEASE PRINT LEGIBLY — TO BE COMPLETED BY THE LOCAL UNION AND/OR WELFARE PLAN

LOCAL UNION NO: ________ REGION/RAB: ________ HOURLY RATE: $________ BASIC GROSS WEEKLY EARNINGS: $________

WAS IRONWORKER ELIGIBLE ON HEALTH PLAN ON DATE OF INCIDENT?		IRONWORKERS LAST EMPLOYER:
LOCATION/STATE OF LAST JOBSITE:	DATE LAST WORKED:	DATE RETURNED TO WORK, IF KNOWN:
DOES THIS LOCAL/HEALTH PLAN OFFER A LOSS OF TIME BENEFIT?		DOES THIS LOCAL/HEALTH PLAN OFFER MATERNITY LEAVE?
WEEKLY AMOUNT FROM UNION: $	WEEKLY AMOUNT FROM HEALTH PLAN: $	WEEKLY AMOUNT FOR MATERNITY: $
ANY OTHER L.O.T. DETAILS:		

PRINT NAME OF SIGNER ____________ PHONE NO. ____________ EMAIL ____________

SIGN HERE► ____________ ____________
AUTHORIZED REPRESENTATIVE DATE SIGNED

Benefits Management Group, Inc.
https://www.bmgiweb.com/IMPACT

I.M.P.A.C.T BENEFIT PLANS
c/o Benefits Management Group, Inc. (BMGi)
625 Enterprise Drive ♦ Oak Brook, Illinois 60523
IMPACT@bmgiweb.com Phone/Fax: 630.828.7000

https://www.impact-net.org

Direct Deposit Enrollment Form

LAST NAME		FIRST NAME		LAST 4 NUMBERS OF SOC. SEC. NO.
HOME ADDRESS INCLUDING CITY – STATE - ZIP				LOCAL UNION NO.
MOBILE PHONE NO.	EMAIL ADDRESS			
BANK NAME	BANK ACCOUNT TYPE	☐ CHECKING	☐ SAVINGS	
BANK ROUTING NO.	BANK ACCOUNT NO.			

In signing this form, I authorize my payment to be sent to the financial institution named above, and if necessary, to electronically debit my account to correct erroneous entries. I am an authorized signer on the account and will notify the IMPACT Office in advance of closing this account.

This authority is to remain in effect until my benefits with I.M.P.A.C.T. OTJA or Maternity Provision Plan cease.

The completed and signed form may be returned via email, fax, or mailed to the address listed above.

_______________________________________ ______ / ______ / ________
Signature **Date**

Attach Voided Check or
Bank Provided Direct Deposit Form

PROCEDURE FOR FILING AN OFJA CLAIM
COMPLETE ONLINE TO AVOID DELAYS

Note that sickness/illness is NOT a covered benefit, nor is wear & tear/ deterioration of muscles/body

- ☐ **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 attending physician and the Local Union
- ☐ **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. Print Legibly or complete digitally (preferred)**
  - Ensure your address, email address, and phone number are current and legible
- ☐ **Check your mail and email (preferred)**
  - 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 info was requested from the doctor, contact them**
  - Be sure your physician's office promptly completes and returns requested info 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 at the time of your injury/accident
- ☐ **When ALL sections are complete, send completed forms to:**

Email: IMPACT@bmgiweb.com (preferred)

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

Phone/Fax: 630-828-7000

Questions? Call 630-828-7000