IMPACT Maternity Benefits 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 maternity claim ☐ Check here if your address is new

SECTION A	TO BE COMPLETED BY THE IRONWORKER			
IRONWORKER NAME		DATE OF BIRTH	ID NO.	SOCIAL SECURITY NO.
HOME ADDRESS	CITY	STATE ZIP		TELEPHONE NO.
EMAIL ADDRESS:				

EXPECTED BIRTH DATE:_____

ARE YOU REQUESTING LEAVE PRIOR TO YOUR EXPECTED BIRTH DATE? ☐YES. ☐NO

IF YES, REQUESTED LEAVE DATE? _____

REASON FOR REQUESTED LEAVE: _____

NAME OF YOUR DOCTOR _____

IF YOU ARE HOSPITALIZED OR HAVE DELIVERED:

NAME OF HOSPITAL/CARE FACILITY:_____

ADDRESS OF HOSPITAL/CARE FACILITY:_____

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	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:
IS THE IRONWORKER A MEMBER ON THE DATE OF REPORTED PREGNANCY? ☐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:
PREGNANCY? YES ☐ NO	APPROXIMATE DATE OF DELIVERY:
DATE PATIENT FIRST CONSULTED YOU FOR PREGNANCY:	IS PATIENT STILL UNDER YOUR CARE FOR PRENATAL/POSTNATAL CARE? ☐YES ☐ NO
PATIENT WAS CONTINUOUSLY UNABLE TO WORK FROM: TO:	LAST DATE WORKED:
POSTNATAL DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK:	DATE IRONWORKER RETURNED TO WORK:

DATE	PHYSICIAN'S NAME (PRINT)	SIGNATURE **X**	DEGREE	TELEPHONE
STREET ADDRESS		CITY – STATE – ZIP CODE		

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. You may take a screen shot of the completed form and email it in.

- ☐ **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 to calculate benefit offsets

- ☐ **BMGI will ask your health plan to verify eligibility on the date of your maternity leave request.**
  - Confirm you are eligible under your health plan

- ☐ **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