EE - GENERAL **EMPLOYEE**

GSA-ILA EMPLOYERS WELFARE FUND

EMPLOYEE'S CLAIM FOR ACCIDENT & SICKNESS BENEFITS FORM

EMPLOYEE: IT IS YOUR RESPONSIBILITY TO READ, COMPLETE ALL SECTIONS 1-18, AND SIGN AND DATE WHERE INDICATED.

HOW TO FILE YOUR CLAIM

This *Claim Form* MUST BE COMPLETED IN FULL and RETURNED with the appropriate ***Medical Care Claim Form*** (i.e., **Accident and Sickness Disability**), which also must be completed and returned by the Physician to:

ILA EMPLOYERS WELFARE FUND, 10 MERSEY WAY, SAVANNAH, GEORGIA 31405 OR
ILA EMPLOYERS WELFARE FUND, POST OFFICE BOX 1280, SAVANNAH, GEORGIA 31402-1280

SECTION A. IDENTIFYING INFORMATION, CLAIM INFORMATION, AND OTHER INSURANCE INFORMATION.

1. Employee's Full Name (Please Print)	**2.** Birthday (Mo/Da/Yr)	**3.** Social Security or AID No.

4. Address: (Street, City, State, Zip)	**5.** Employee's Daytime Telephone Number:

6. Briefly describe the condition(s) for which you received medical services (you can usually identify the sickness or injury by copying the diagnosis or description of services from the provider bill):

7. Date of onset of sickness, disease or bodily injury (Mo/Da/Yr):	**8.** Date first treated for this condition (Mo/Da/Yr):	**9.** Is sickness, disease, or bodily injury: ☐ New OR ☐ Recurring
10. Briefly describe how the sickness, disease, or bodily injury occurred:		**11.** Name and type of Treating Physician(s) (i.e., MD, psychologist, chiropractor, etc.):
		12. Date(s) of Service (Mo/Da/Yr)

13. Is injury due to automobile accident? ☐ Yes ☐ No

14. Have you or do you intend to claim benefits from any other source (including unemployment benefits)? If so, please state:

_____

15. Has or will a claim be filed under any Worker's Compensation Act or similar law? ☐ Yes ☐ No

(a) If you have filed, or intend to file, a Workers' Compensation claim, please list the Employer(s) you were working for when the sickness, disease, or bodily injury occurred: _____

16. Date last worked (Mo/Da/Yr): _____

17. Are you employed anywhere else? ☐ Yes ☐ No
(a) If Yes, please list the Employer(s): _____

18. Dates during which you were unable to work because of sickness, disease, or bodily injury which required treatment by a Physician.
From _____ to _____

(a) Is the time period of disability described **above**, due to the same or a related cause for which this claim was filed? ☐ Yes ☐ No
If Yes, please briefly explain as to the same or related cause (i.e., list name of the Employer(s), describe how the sickness, disease, or bodily injury is due to the same or related causes, etc...):

SECTION B. *ACKNOWLEDGMENT* AND *RELEASE*

COUNTY OF CHATHAM) ***ACKNOWLEDGMENT***
STATE OF GEORGIA)

The undersigned hereby certifies that the information provided in his/her *Claim for Benefits* is complete and true to the best of his/her knowledge and belief, and that no relevant information relating to the *Claim* has been withheld. The undersigned further acknowledges and affirms that he/she is only to fill out this *Claim Form*, and that the undersigned is ***not*** to complete the *Medical Care Claim Form(s)*, which must be filled out by the Physician or Supplier. The undersigned hereby further understands that if he/she makes a false statement and collects money fraudulently from the **GSA-ILA EMPLOYERS' WELFARE FUND** (hereinafter the "Fund"), that: 1) his/her eligibility for benefits may terminate; and 2) if the Fund has paid benefits contrary to the purpose of the Fund, that the Fund may recover said monies from the person to or for whom the payments were made, including directly. The undersigned hereby further acknowledges that he/she understands that it is a crime to knowingly make false statements and representations of fact, or knowingly conceal, cover-up, or fail to disclose any required fact, in any document required by or that is necessary to verify, explain, clarify or check for accuracy and completeness of any report required by the Employee Retirement Income Security Act of 1974 ("ERISA") and that any false statement or representation made in reporting on his/her *Claim* may subject him/her to prosecution under 18 U.S.C. §1027, the penalty for which is a fine of $10,000.00 or imprisonment of five (5) years or both, or under any applicable state law.

I hereby authorize **release** to and use by the *GSA-ILA Employers Welfare Fund* of any medical or other information requested or needed in processing this *Claim*. I hereby certify to the above statements.

Date: _____ Person Applying for Benefits sign here **X** _____

Social Security or AID No. _____

ACCIDENT & SICKNESS DISABILITY

GSA-ILA EMPLOYERS WELFARE FUND ACCIDENT AND SICKNESS DISABILITY MEDICAL CARE CLAIM FORM

PHYSICIAN OR SUPPLIER

PHYSICIAN OR SUPPLIER: IT IS YOUR RESPONSIBILITY TO ENSURE THIS FORM IS COMPLETE AND TO SIGN BELOW.

SECTION A. PATIENT AND EMPLOYEE (SUBSCRIBER) INFORMATION

1. Patient's Full Name (Please Print)

2. Patient's Address (Street, City, State, Zip)

3. Patient's Birthdate (Mo/Da/Yr)

4. Patient's Sex:
☐ Male ☐ Female

5. Patient's Relation to Insured
Self ☐ Spouse ☐ Child ☐ Other ☐

6. Was Condition Related to:
A. On the job injury:
☐ Yes ☐ No
Explain: _____
B. Accidental Injury:
☐ Yes ☐ No
Explain: _____
C. Auto Accident:
☐ Yes ☐ No
Explain: _____

7. Employee's Full Name (Please Print)

8. Employee's Address (Street, City, State, Zip)

9. Employee's Birthdate (Mo/Da/Yr)

10. Employee's Social Security or AID Number

11. Employee's Daytime Telephone Number

12. Other Health Care Coverage – Enter name of policyholder, Plan name, address, and policy or medical assistance number:

13. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. *I Authorize the Release of any Medical Information Necessary to Process this Claim.*

SIGNED _____

DATE _____

14. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE(S) DESCRIBED BELOW. THIS AUTHORIZATION IS INVALID UNLESS TAXPAYER IDENTIFICATION NUMBER (TIN) OF PHYSICIAN OR SUPPLIER IS PROVIDED BELOW.

SIGNED _____

DATE _____

SECTION B. EXAMINING PHYSICIAN OR SUPPLIER INFORMATION – TO BE COMPLETED BY PHYSICIAN OR SUPPLIER

15. Physician or Supplier's Full Name (Please Print):

Physician or Supplier's Address: (Street, City, State, Zip)

16. Telephone Number:

17. Taxpayer Identification Number (TIN) or the Physician or Supplier's Social Security Number:

18. Patient's Account No.:

SECTION C. EVALUATION AND DIAGNOSIS. *Please attach any related medical records and test results which enabled you to make your diagnosis.*

19. Date of Illness (First Symptom) or Injury (Accident) (Mo/Da/Yr):
_____

20. Date Patient First Consulted you for this Condition (Mo/Da/Yr):
_____

21. Date Patient able to Return to Work (Mo/Da/Yr):
_____

22. Is Patient unable to work at his/her regular job because of sickness, disease, or bodily injury which required the treatment referenced herein?
☐ Yes ☐ No

23. Dates during which the Patient was unable to work at his/her regular job because of sickness, disease, or bodily injury which required treatment (Mo/Da/Yr):
From: _____ To: _____
From: _____ To: _____
From: _____ To: _____

NOTE: The dates of disability cannot be prospective, but may only be through the date of this *Medical Care Claim Form.

24. Are the time periods of sickness, disease, or bodily injury described above in **Number 23**, due to the same or related causes? ☐ Yes ☐ No

25. Dates of Service (Mo/Da/Yr)		Procedure Codes	Place of Service Codes	Diagnosis Codes	**26.** Please briefly describe the diagnosis or nature of sickness, disease, or bodily injury:	**27.** Fully Describe the Procedures, Medical Services, or Supplies Furnished for Each Date Given:
From	To					

COUNTY OF CHATHAM)
STATE OF GEORGIA)

ACKNOWLEDGMENT

The undersigned hereby acknowledges that he/she understands that it is a crime to knowingly make false statements and representations of fact, or knowingly conceal, cover-up, or fail to disclose any required fact, in any document required by or is necessary to verify, explain, clarify or check for accuracy and completeness of any report required by the Employee Retirement Income Security Act of 1974 ("ERISA") and that any false statement or representation made in reporting may subject him/her to prosecution under 18 U.S.C. §1027, the penalty for which is a fine of $10,000.00 or imprisonment of five (5) years or both. By signing below, the undersigned further hereby acknowledges and agrees to periodic audits in reference to said claims by GSA-ILA Employers Welfare Fund auditors. I further hereby certify that the procedures as indicated above have been completed and that the fees submitted are the actual fees I have charged this patient and intend to accept for those procedures.

(Name of Physician) _____ Date: _____ Physician or Supplier signs here **X** _____

Please file claim and related documents with:

Mailing Address:
ILA EMPLOYERS WELFARE FUND
POST OFFICE BOX 1280
SAVANNAH, GEORGIA 31402-1280

PLACE OF SERVICES CODES

11 – Office	33 – Custodial Care Facility	65 – End-Stage Renal Disease Treatment Facility
12 – Home	34 – Hospice	71 – 72 – Health Clinic
21 – Inpatient Hospital	41 -42 – Ambulance (land, air or water)	81 – Independent Laboratory
22 – Outpatient Hospital	51 – 52 – 56 – Psychiatric Facility	99 – Other Place of Service