LOSS OF INCOME BENEFIT STATEMENT OF CLAIM

MAIL TO:

RAILROAD MAINTENANCE AND INDUSTRIAL HEALTH AND WELFARE FUND

2725 West Monroe Street
Springfield, Illinois 62704
Phone: (217) 787-2923

Participant's Name: _____

Social Security Number: _____ Date of Birth:_____

Address:_____

_____

Participant's Current or Last Employer:_____

Local Union No.: _____

Complete if Disability is due to an Accident:

1. Date of Accident:_____
2. Location of Accident:_____
3. Give Details of Accident:_____

   _____

Complete if Disability is due to an Illness:

1. Date Symptoms First Appeared:_____
2. Nature of Illness:_____

Is this Disability Due to your Occupation? ☐ Yes ☐ No

Is this Disability Covered by any Workers' Compensation or Occupational Disease Law? ☐ Yes ☐ No

First Full Day Unable to Work:_____

Date Resumed Work:_____
Or
Date Expected to Resume Work:_____ ☐ Undetermined

Did you receive any wages during your period of Disability? ☐ Yes ☐ No

I certify that the above information is true and correct. I hereby authorize all doctors, hospitals, or other institutions rendering care and treatment to furnish the Railroad Maintenance and Industrial Health and Welfare Fund with full information regarding treatment rendered (including copies of records).

_____ _____
Signature Date

ATTENDING PHYSICIAN MUST COMPLETE REVERSE SIDE

ATTENDING PHYSICIAN'S STATEMENT

Participant's Name:_____ SSN:_____

Diagnosis and Concurrent Conditions:

Primary Diagnosis:_____ ICD Code:_____

Secondary Diagnosis:_____ ICD Code:_____

_____ ICD Code:_____

_____ ICD Code:_____

Is Condition due to injury or illness arising out of patient's employment? ☐ Yes ☐ No

Date Symptoms first appeared or accident occurred: _____

Date patient first consulted you for this condition:_____

Has patient ever had the same or similar condition? ☐ Yes ☐ No

If "Yes," when and describe:_____

Is patient still under your care for this condition? ☐ Yes ☐ No

For purposes of this form, "Totally Disabled" means that the patient is prevented by an accident or illness from engaging in his/her regular employment.

Patient was continuously Totally Disabled during the period from _____ through _____

If still disabled, the patient should be able to return to his/her regular employment on _____

_____ _____

Physician's Signature Date

_____

Physician's Name (Print) Degree Telephone No.

_____

Street Address City State Zip

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