WEEKLY INDEMNITY DISABILITY CLAIM FORM

IRON WORKERS BENEFIT TRUST
1470 WORLDWIDE PLACE • VANDALIA, OHIO 45377-1156
Phone (800) 331-4277 • FAX (937) 454-5457

TO BE COMPLETED BY IRONWORKER • FORM MUST BE COMPLETED IN FULL

IRON WORKER'S NAME	DATE OF BIRTH	SOCIAL SECURITY #	LOCAL UNION NO.

IRON WORKER'S ADDRESS (NO., STREET, CITY, STATE, ZIP)

DATE YOU LAST WORKED	AREA CODE + PHONE NUMBER	WHEN DID YOU BECOME TOTALLY DISABLED (UNABLE TO WORK)

IF HOSPITALIZED, GIVE NAME OF HOSPITAL	DATES CONFINED TO HOSPITAL FROM TO

NAME OF ATTENDING PHYSICIAN	PHYSICIAN'S ADDRESS & TELEPHONE NUMBER

CAUSE OF DISABILITY

IS DISABILITY DUE TO AN ACCIDENT? ___YES ___NO (IF YES, PLEASE COMPLETE THE FOLLOWING SECTION *IN FULL)*	WAS THIS WORK RELATED IN NATURE? (NOT WEAR & TEAR) ___YES ___NO

DATE OF ACCIDENT	PLACE ACCIDENT OCCURRED (COMPLETE DESCRIPTION AND WHO WAS INVOLVED)

I AUTHORIZE RELEASE OF ANY INFORMATION PERTAINING TO THIS CLAIM. I CERTIFY THAT ALL INFORMATION GIVEN IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

MEMBER'S SIGNATURE: _____ DATE: _____

IF YOU SUBMIT A CLAIM FOR BENEFITS AS THE RESULT OF AN ACCIDENT, INJURY OR ILLNESS INVOLVING A THIRD PARTY, YOU, THE PARTICIPANT, MUST SIGN, DATE AND HAVE WITNESSED THE FOLLOWING REIMBURSEMENT AND SUBROGATION AGREEMENT

AGREEMENT

The Benefit Trust was created to provide you and your dependents with hospitalization, surgical, medical care and/or short-term disability benefits as the result of any accident, injury or illness you or your dependents may experience. Due to the dramatic rise in the cost of providing such benefit that has occurred in the past several years, the Board of Trustees has adopted a policy granting the Benefits Fund a right to seek either reimbursement or subrogation with respect to any claims paid on behalf of you and your dependents when a third party is legally responsible for causing the underlying loss, illness or injury on which payment were made by the Benefit Trust.

Therefore, by signing this Agreement you acknowledge and agree that the Benefit Trust is subrogated to all rights of recovery available to you and your dependents regardless of whether you or your dependents obtain a full or partial recovery from such third party, including, but not limited to, the insurer of such third party and that the failure to sign and return this Agreement entitles the Benefit Trust to deny coverage for the subject loss, injury or illness. In addition, you further acknowledge and agree that the Benefit Trust has a subrogated interest from any insurance held by you or your dependents, including coverage for medical payments, underinsured and/or uninsured motorists coverage, at fault or no-fault insurance, casualty or liability insurance, or payments received under a workers' compensation system.

Further, you acknowledge and agree that the full amount of the benefits paid by the Benefit Trust will be subject to recovery without regard to any collateral source of recovery. The Benefit Trust reimbursement and subrogation rights will take priority over any and all rights of recovery held by you or your dependents against such third person with respect to the event(s) that triggered the payment of benefits. The Benefit Trust subrogated interest will apply regardless of whether you or your dependents have been or will be made whole and regardless of whether you or your dependents have incurred fees or costs to obtain a recovery from any third party or the insurer of such third party. You hereby acknowledge and agree that the "make whole" doctrine or any similar doctrine or common law rule with respect to the reimbursement and subrogation rights of the Benefit Trust do not apply.

In addition, you further acknowledge and agree that the "common fund" doctrine or any similar doctrine or common law rule with respect to the reimbursement and subrogation rights of the Benefit Trust do not apply.

You further acknowledge that a complete description of the reimbursement and subrogation rights granted to the Benefit Trust is set forth in the Summary Plan Description and that by executing this Agreement you hereby agree to be bound by the provisions and conditions set forth in both this Agreement and the Summary Plan Description.

MEMBER'S SIGNATURE: _____ WITNESS SIGNATURE: _____

DATE: _____ DATE: _____

ATTENDING PHYSICIAN'S STATEMENT

TO BE COMPLETED BY ATTENDING PHYSICIAN • FORM MUST BE COMPLETED IN FULL

Diagnosis and Concurrent Conditions

Is Condition Due to Injury or Sickness Arising Out of Patient's Employment?

YES ❑ NO ❑ If Yes, please advise how, when and where (no wear & tear)

Pregnancy?

YES ❑ NO ❑ If Yes, Approximate Date Pregnancy Commenced

REPORT OF SERVICES (If Previous Form Submitted to this Carrier, You Need Show Only Dates and Services Since Last Report)

Date of Services	Place of Services †	Description of Surgical or Medical Services Rendered

†O - Doctor's Office IH - Inpatient Hospital NH - Nursing Home

H - Patient's Home OH - Outpatient Hospital OL- Other Locations

Date Patient First Consulted You for this Condition.

Patient Still Under Your Care for this Condition?

YES ❑ NO ❑ If No, please advise name and address of physician if care was transfered.

Patient Was Continously Totally Disabled (Unable to Work)

From Thru

If Still Disabled, Date Patient Should Be Able to Return to Work.

Does Patient Have Other Health Coverage?

YES ❑ NO ❑ If Yes, Please Identify

Date Physician's Name (Print) Degree*

Provider's TIN or SS# **Claim will not be processed without the Tax I.D. Number.**

Physician's Signature

MUST BE FURNISHED UNDER AUTHORITY OF LAW

STREET ADDRESS CITY OR TOWN STATE ZIP CODE

TELEPHONE #

*** MUST BE AN M.D., D.O., OR D.P.M. - Chiropractors are not accepted.**