Operating Engineers Local 99 Health and Welfare Fund
3615 North Point Blvd Suite C
Baltimore, MD 21222
Phone No. 410-254-9595 / 1-800-367-7848
Fax No. 410-254-2016

Short Term Weekly Disability Packet

OEBF Local 99
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Claim Packet Instructions
Short Term Disability Benefits

Your Disability Benefit Claim

This packet contains the forms necessary to apply for Short Term Weekly Disability benefits through your health plan. It also addresses common questions about Disability claims. Please save this material for your future reference.

How To Apply For Benefits

Step 1
Please see page 4. Complete the "Employee Statement" then have the Human Resource Department of your employer complete the "Employer's Statement."

Step 2
See page 5. Sign and date the "Authorization to Obtain and Release Information." This authorization will only be used for purposes related to this disability claim.

Step 3
After pages 4 and 5 are completed in their entirety they can be submitted to OEBF 99 Disability via US Mail to 3615 North Point Blvd Suite C, Baltimore, MD 21222 or faxed to 410-254-2016 Attention OEBF 99 Disability.

Step 4
Have your treating physician complete the "Attending Physician's Statement," this is page 6. If more than one physician is treating you for your disabling condition, you may wish to have each complete a form. Additional forms are available upon request. The *original* completed form must be returned to OEBF 99 Disability 3615 North Point Blvd Suite C, Baltimore, MD 21222 or faxed directly from the physician's office to 410-254-2016.

*Fees for completing the Disability packet are not covered by your health plan.

Step 5
After all of your Disability forms are completed and submitted to the OEBF 99, your claim will be reviewed. Processing will take approximately 10 business days, you will receive a benefit check within this time frame or other notification from the OEBF 99.
To avoid a possible overpayment on your claim, please inform OEBF immediately if you receive other benefits, retire or return to work. It is your responsibility to repay any amounts paid to you in error.

When you Return to Work

Your disability benefits usually stop when you return to work. Be sure you notify OEBF immediately when you plan to return, or have returned to work to assure no overpayment occurs. A copy of the release for work slip is required.

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Benefits

- A 7 day waiting period applies for illness or pregnancy related disabilities, the waiting period may be waived for accident or injury related conditions if certain criteria is met.
- Maximum Period of Benefit is 26 weeks
- $1,000.00 per week, F.I.C.A. taxes will be deducted
- You may be responsible for providing periodic updates regarding your continued disability
- Please contact the Union Hall regarding your Union Dues and notify them you are receiving Short Term Disability Benefits. Their number is 202-337-0099.

Direct deposit is not currently available. Checks are generally available for pickup on Friday after 12, you must make prior arrangements with the Fund Office if you wish to pick up your check. Checks will generally leave the Fund Office on Friday afternoon. Please allow time for delivery, it is not uncommon for the Post Office to take 7-10 days for delivery during busy seasons. The Fund Office can issue a replacement check after 2 weeks if you have not received your payment. Please note, this schedule is subject to change.

Double check your mailing address! Payment will be issued to the address shown on this Disability Packet. If your address is different please contact the Fund Office and ask to speak with the Registration Department to change your address prior to turning in your Short Term Disability Claim Forms.

Claim Form Fraud Notice

The Trustees have the right to rescind any coverage of the Employee and/or Retiree and/or Dependents for making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage or obtaining benefits under the Plan. The Trustees may either void coverage for the Employee and/or covered Retirees and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Trustee's discretion, or may immediately terminate coverage. The Trustees reserve the right to collect additional monies if claims are paid in excess of the Employee's and/or Retiree's and/or Dependent's paid contributions.

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EMPLOYEE / EMPLOYER STATEMENT

Short Term Disability Benefits

EMPLOYEE STATEMENT *to be completed by Employee*

For a prompt review of your claim, ALL of this form must be thoroughly completed by the appropriate persons

Full Name		Employer/Company Name		
Medical ID No.	Phone No.	Birth Date _____/_____/_____	Sex	
Address		City	State	Zip
Email address:				

1. Is your disability work related? Yes No If yes, have you filed a Worker's Compensation claim?

2. Last date at work before disability _____ Date you returned or expect to return to work _____

3. Cause of Disability: Accident Illness Pregnancy If accident or illness, please explain (include date and location, if applicable)

4. Please describe all work activity, including self-employment since the start of your disability. If none, initial here _____

5. Are you Retired or do you intend to retire within the next 6 Months?
Yes _____ No _____ If yes state date of Retirement. _____

Acknowledgement - I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief. I acknowledge that I have read the Fraud notice on page _3_ of this form.

Signature _____ Date _____

EMPLOYER'S STATEMENT *to be completed by employer Human Resource Department* ***ONLY***

Employee's Full Name	Last 4 of Social Security No.	Birthdate
Work Location Address		
Job Title *Please attach a copy of the job description if available*		

1. Is disability work related? Yes No Undetermined 2.Has the employee filed for Workers' compensation Yes No

3. Date last worked? _____ 4. Date employee returned to work _____

5. Job status when disability began: Full-time (_____hours/week) Part-time (_____hours/week)

The company is obligated to pay for any part of the month worked for continuing employees, completion of this form serves as confirmation of payment for the month the employee stopped working.

Employer Name (Print)	Phone No.		
Mailing Address	City	State	Zip
Name of employer representative completing this form (Print)	Title		

Acknowledgement - By signing below, I Certify that the employer will remit payment for the month the employee stopped working. I also certify that the answers I have provided to the above questions are complete and true to the best of my knowledge and belief.

Signature _____ Date _____

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AUTHORIZATION TO OBTAIN AND RELEASE INFORMATION
Short Term Disability Benefits

I authorize these persons having any records or knowledge of me or my health:

- Any physician, medical practitioner or health care provider.
- Any hospital, clinic, pharmacy or other medical or medically related facility or association.
- Any educational, vocational or rehabilitation counselor, organization or program.
- Any government agency (for example, Social Security Administration, Public Retirement System, Worker's Compensation Board, etc.)

To give this information:

- Charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing and test results. Prognosis and treatment of any physical or mental condition, including:
  - Any disorder of the immune system, including HIV, Acquired Immune Deficiency Syndrome (AIDS) or other related syndromes or complexes.
  - Any communicable disease or disorder.
  - Any psychiatric or psychological condition, including test results, but excluding psychotherapy notes. Psychotherapy notes do not include a summary of diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date.
  - Any condition, treatment, or therapy related to substance abuse, including alcohol and drugs.

and:

- Any non-medical information requested about me, including such things as education, employment history, earning or finances, return to work accommodation discussions or evaluations and eligibility for other benefits or leave periods including but not limited to claims status, benefit amount, payments, settlement terms, effective and termination dates, plan or program contributions, etc.

Health and Welfare Trust Fund for International Union of Operating Engineers Local 99 and 99A

- I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct the persons and organizations identified above to release and disclosed my entire medical record without restriction.
- I understand that the Fund Office will gather my information only if they are administering or deciding my disability claims(s), and will use the information to determine my eligibility or entitlement for benefits.
- I understand that I have the right to refuse to sign this authorization and a right to revoke this authorization at any time by sending a written statement to the Fund Office, except to the extent the authorization has been relied upon to disclose requested records. A revocation of the authorization, or the failure to sign the authorization, may impair the Fund Office ability to evaluate or process my claim(s), and may be a basis for denying or closing my claim(s) for benefits.
- I understand that in the course of conducting its business the Fund Office may disclose to other parties information about me. They may release information to a reinsurer, a plan administrator, plan sponsor, or any person performing business or legal services for them in connection with my claim(s). I understand that the Fund Office will release information to my employer necessary for absence management, for return to work and accommodation discussions, and when performing administration of my employer's self-funded (and not insured) disability plans.
- I understand that the Fund Office must comply with state and federal laws and regulations enacted to protect my privacy. I also understand that the information disclosed to them pursuant to this authorization may be subject to disclosure with my authorization or as otherwise permitted or required by law. Information retained and disclosed by the Fund Office may not be protected under the Health Insurance Portability and Accountability Act (HIPAA).
- I understand and agree that this authorization is used to gather information shall remain in force from the date signed below:
  - For the Fund Office, the duration of my claim(s) or 24 months, whichever occurs first.
- I understand and agree that the Fund Office may share information with each other regarding my disability. This authorization to share information shall remain valid for 12 months from the dated signed below.
- I acknowledge that I have read this authorization. A photocopy or facsimile of this authorization is as valid as the original and will be provided to me upon request.

Name (please print) _____ Medical ID Number _____

Signature of Claimant/Representative _____ Date _____

If signature is provided by legal representative (e.g. Attorney in Fact, guardian or conservator), please attach documentation of legal status.

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ATTENDING PHYSICIAN'S STATEMENT

Short Term Disability Benefits

To be completed by the Attending Physician

The following information is needed to document the patient's inability to work. The patient is responsible for obtaining a completed form without expense to OEBF. Please complete this form and mail or fax it to OEBF using the contact information listed above.

Patient Name (Print)	Patient Date of Birth	Medical ID Number
	/ /	

1. DIAGNOSIS	ICD-10 with description

2. PREGNANCY (if applicable)	A. Expected date of delivery	B. Actual date of delivery	Vaginal C-section
	/ /	/ /	

3. HISTORY and TREATMENT	A. Date you recommended the patient stop work	B. Date symptoms appeared or accident occurred?
	/ /	

C. Has the patient ever had the same or similar condition? Yes No If yes, when?

D. Is this condition related to the patient's employment? Yes No

E. Frequency of subsequent visits: Weekly Monthly Other _____ F. Date of most recent visit?

G. Hospitalization?	H. Date Admitted Date Discharged	I. Surgery?	J. Date Surgery Completed/Scheduled
Yes No	/ / / /	Yes No	/ /

4. LEVEL OF FUNCTIONAL IMPAIRMENT

How long do you expect these limitations and restrictions to continue (functional capacity).

Return to work date _____ Unable to determine - follow up in _____ weeks / months (circle one) Permanently

Date of next scheduled visit? / /

5. PHYSICIAN INFORMATION *Please type or print*

Name and address of physician completing form	Specialty	
	Phone No.	Fax No.

Acknowledgement - I certify that the answers I have made to the above questions are completed and true to the best of my knowledge and belief.

Signature	Date