EE - GENERAL **GSA-ILA EMPLOYERS WELFARE FUND** **EMPLOYEE**

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** _____