DISABILITY CLAIM

NORTHERN ILLINOIS BENEFIT FUND

1295 Butterfield Road - Aurora, IL 60504-8879
(630) 978-4600 • Fax (630) 978-4616

THIS FORM FOR EMPLOYEE WEEKLY INCOME BENEFITS ONLY
DO NOT USE IT TO FILE YOUR MEDICAL BILLS

EMPLOYEE'S STATEMENT

EMPLOYEE'S NAME		EMPLOYEE'S ADDRESS	
TELEPHONE No.	SOCIAL SECURITY No.	DATE OF BIRTH	NAME OF EMPLOYER
LAST DAY WORKED	RETURN TO WORK DATE	ARE YOU NOW DISABLED? ☐ YES ☐ NO	CLAIM IS DUE TO: ☐ SICKNESS ☐ ACCIDENT ☐ PREGNANCY
DESCRIBE SICKNESS OR INJURY		IS DISABILITY WORK RELATED? ☐ NO ☐ YES GIVE DETAILS	
IF CLAIM IS DUE TO ACCIDENT:	DATE ACCIDENT HAPPENED	DID ACCIDENT HAPPEN AT WORK? ☐ YES ☐ NO	

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Physician to release any information acquired in the course of my examination or treatment. I further authorize the Northern Illinois Benefit Fund to release any information to the Northern Illinois Pension Fund and the Northern Illinois Retirement Fund for the purpose of determining eligibility for disability pension benefits.

Signed (Patient): _____ Date: _____

ATTENDING PHYSICIAN'S STATEMENT

DIAGNOSIS (INCLUDING COMPLICATIONS)

WAS SURGERY PERFORMED? ☐ YES ☐ NO DATE PERFORMED: _____	TYPE OF SURGERY: ☐ IN-PATIENT ☐ OUT-PATIENT
IS PATIENT'S CONDITION DUE TO: PREGNANCY ☐ YES ☐ NO DATE COMMENCED _____ EMPLOYMENT ☐ YES ☐ NO PLEASE EXPLAIN _____	DATE OF FIRST TREATMENT: _____ FREQENCY OF MOST RECENT TREATMENT: _____ DATE OF MOST RECENT TREATMENT: _____

☐ IS PATIENT TOTALLY DISABLED? ☐ IF NOT DISABLED, PLEASE EXPLAIN:
DATES OF HOSPITALIZATION: FROM _____ THRU _____
DATES OF DISABILITY: FROM _____ THRU _____
ESTIMATED RETURN TO WORK DATE _____

DATE	PHYSICIAN'S NAME (Print)	DEGREE	SIGNATURE:
ADDRESS		FED. I.D. #	PHONE #

WAIVER OF PREMIUM FOR LIFE INSURANCE

If you become totally and permanently disabled and unable to work for nine months or longer, your Life Insurance may be continued under waiver of premium rules. Please see the Life Insurance section of the SPD for further information.