Electrical Workers Administration and Claims Office

General Welfare, Vacation, Pension & Retirement Savings Funds

28600 Bella Vista Parkway, Suite 1110
Warrenville, IL 60555-1600

Phone (630) 393-1701
Fax (630) 393-3615

➢ ***CLAIM FOR LOSS OF TIME BENEFITS*** ***You must notify the fund the date you return to work**

NAME:______________________________ SS # ____________________

STREET:______________________________ PH # ____________________

CITY, STATE, ZIP:____

EMPLOYER AT TIME OF DISABILITY: ______________________________

I CERTIFY THAT I HAVE BEEN DISABLE FROM ____________________ TO ____________________

NATURE OF DISABILITY:____

ORIGINAL DATE OF ACCIDENT: ____________ WORK RELATED? YES ☐ NO ☐

*** * * * * FEDERAL INCOME TAX WITHHOLDING NOTICE * * * * ***

Both workers compensation and non-workers compensation Loss of Time benefits are taxable as regular income in the year received. You will receive a form W2 at the end of each calendar year in which you receive any type of Loss of Time benefits, indicating the amounts to be included in federal and state taxable income.

Federal income tax will be withheld at a rate of 20% beginning with the fifth Loss of Time benefit payment. In order to elect to have no federal income tax withheld, you must check the appropriate box below, sign, and return this form to the Fringe Benefit Office. In the absence of a tax election and signature on this form, the 20% withholding will begin with the fifth non-workers compensation Loss of Time benefit payment.

- ☐ **Please begin 20% withholding of federal income taxes with my fifth Loss of Time benefit payment.**
- ☐ **I *do not* wish to have federal income taxes withheld from my weekly Loss of Time benefit payment. I understand that Loss of Time benefits are taxable as regular income in the year received.**

____________________ ______________________________
Date Member's Signature

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➢ ***DOCTOR'S STATEMENT*** **(must be completed by doctor)**

DIAG. CODE: ____________ DIAGNOSIS:______________________________

1ST DAY UNABLE TO WORK (THIS INCIDENT):____________ 1ST DAY OF TREATMENT:____________

IF 1ST DAY OF TREATMENT IS OTHER THAN 1ST DAY UNABLE TO WORK -- NAME OF REFERRING PHYSICIAN:

THIS PATIENT WAS REFERRED TO ME BY:______________________________

APPROXIMATE DATE ABLE TO RETURN TO WORK: ____________ UNDETERMINED AT THIS TIME > ☐

NAME:____________________ DEGREE:____________ PHONE NO:____________

DATE: ____________ DOCTOR'S SIGNATURE: ______________________________