OHIO LABORERS Benefits

SHORT TERM DISABILITY FORM

MEMBER INSTRUCTIONS

- Please complete the top section of this form in full. The member must sign and date this section. By signing this form, the member authorizes the physician to release Protected Health Information (PHI) to Ohio Laborers Benefits, as described on page 2. Give this form to disabling physician's office to complete the bottom physician's section.
- Once completed by the member and physician, submit the form by:

  Email: insurance@ohiolaborers.com,
  Mail: Ohio Laborers Benefits, 800 Hillsdowne Rd, Westerville, OH 43081, or
  Fax: 614-898-9176

- Members may submit a Federal W-4 and/or Ohio State Tax Withholding Form. If these forms are not submitted, taxes will be withheld at the standard rate of Single with Zero Allowances.

Member's name	Social Security Number	Telephone number
Mailing address	City and State	Zip Code
Date of birth	Nature of sickness or injury	Date accident or sickness began
Last date worked (exact date required)	Date returned to work (if applicable)	Is Injury or sickness work related? ◯ Yes ◯ No
If Injured, How and Where did Accident Happen?		
Member's Signature	Date Completed	

PHYSICIAN INSTRUCTIONS

- Please complete the bottom section of this form in full. The physician must sign and date this section.
- Please provide actual dates of disability for the above referenced member. If exact dates are undetermined, please provide estimated dates. Claims with vague/undetermined disability periods cannot be processed properly. If this member is permanently disabled from laboring, please right "Permanent" on the "thru" line below.

Diagnosis of Disabling Condition (ICD-10 Code)		
Should this claim be filed with Workers' Compensation? ◯ Yes ◯ No	Date first consulted for this condition	
Patient continuously totally disabled (Unable to Work) From_____ Thru_____	If still disabled, approximate date the patient should be able to return to work Date required _____	
Physician's name (print)	Physician's signature	Date completed
Address	Phone #	Fax #

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Authorization for Release of Protected Health Information to the Ohio Laborers' District Council - Ohio Contractors' Association Insurance Fund and the Laborers' District Council and Contractors' Pension Fund of Ohio

Information about the Use or Disclosure

By signing this form on the reverse side (or page 1 of this document), the member is authorizing the Disabling Physician (the healthcare provider to which the member gives this form) to release Protected Health Information to the OLDC-OCA Insurance Fund and the LDC&C Pension Fund of Ohio (aka Ohio Laborers Benefits).

The member hereby authorizes the use or disclosure of his/her individually identifiable health information as described below. ***The member understands that this authorization is voluntary and that he/she may revoke it at any time by submitting a revocation in writing to the healthcare provider(s).***

Specific description of information to be used or disclosed (including date(s)): **The member who signed the reverse side authorizes the healthcare provider(s) to disclose protected health information received by and created by the healthcare provider(s) relating to any condition, illness, or injury for which the member is asserting has rendered him/her eligible for disability benefits, and any other information required by Ohio Laborers Benefits in connection with his/her application for disability benefits.**

Specific purpose of the disclosure: **At the request of the Individual (Member).**

This authorization will expire **within 360 days from the date it is executed.**

Important Information about the Individual's (Member's) Rights

The member has read and understood the following statements about his/her rights:

- The member may revoke this authorization at any time before its expiration date by notifying his/her health care provider(s) in writing, but the revocation will not have any effect on any actions the entity took before it received the revocation. The member's right to revoke an authorization is outlined in his/her health care provider(s)' Privacy Notice.
- The member may see and copy the information described on this form if he/she asks for it.
- The member is not required to sign this form to receive his/her health care benefits (enrollment, treatment, or payment), except in very limited circumstances.
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving entity and no longer protected by the privacy regulations.

Notice: The use of this Authorization to request medical information on behalf of the member for disability benefits does not obligate Ohio Laborers Benefits to accept or honor any charge for the provision of medical information to Ohio Laborers Benefits. Any fees charged for medical information are the sole responsibility of the member.