South Central United Food and Commercial Workers Unions and Employers Health and Welfare Trust
661 N. Ericson Rd., Cordova, TN 38018 • Toll Free: 1·800·874-8499 • Fax: 1·901-758-3021

Loss of Time Instructions and Claim Forms

The following action is **required on your part** before we can determine if you are eligible to receive Loss of Time Benefits. There are three forms that have to be completed in their entirety, those forms are enclosed.

1.) Part A: **YOU,** the policy holder/employee statement.
2.) Part B: **EMPLOYER**, Store Management/Leadership.
3.) Part C: **PHYSICIAN,** some physicians may charge you for the completion of this form. Any such charge would be your responsibility.
4.) Final Step: Employee returns all forms **(please do not send partial forms or packets) to:** The Fund Office (3 options) **Fax: 901-758-3021, Upload: www.bams.bz, Mail: Address Above.** * Incomplete claims will not be processed or returned**.**

Make sure your name and social are on EACH page should documents get separated.

Timeline: For **complete and approved** claims we make every effort to process within 7 business days. In example, if you mail documents on a Thursday, a payment will not be issued until the following Thursday. We process payments every Thursday. Denied Claims: The Fund will inform you within 45 days if your claim is denied.

MetLife: They are in charge of handling the paperwork for Kroger to place your job on hold. MetLife is a company Kroger hired; it is not a part of the Union Benefit Office. Please address all MetLife questions with Kroger, their HR, your management, or with MetLife. MetLife Fax: 1-800-230-9531. Phone: 1-888-343-6886.

Non-work-Related Accidents: Involving cars, businesses, attorneys, other responsible third parties, insurances, lawsuits ect, require SUBROGATION documents to be completed. Benefits are not payable without them

Workmen's Comp: If you injured yourself at work, you must contact your Risk Management representatives. The Fund benefits office will NOT consider you for any Loss of Time benefits/medical leave pay until you have a minimum of two workman's' comp denial letters.

LOSS OF TIME BENEFIT: The Fund's Loss of Time Benefit is available only to eligible Employees in Plan A, B or C who miss work due to certain qualifying Non-occupational Illness or Injury. Employees in Plans B and C must have two years of Employment to be eligible for the Loss of Time Benefit.

	Plan A	**Plan B**	**Plan C**
Amount of Weekly Benefit	60% of Salary	50% of Salary	50% of Salary
Maximum Weekly Benefit	$350	$300	$300
Maximum Benefit Period	26 Weeks	13 Weeks	13 Weeks

Benefit Begins: Benefits begin on the 5th day of Illness or Injury

Where this document differs from the Plan's Summary Plan Description Booklet, the SPD is precedent. Please refer to your SPD.

Part A: POLICY HOLDER'S STATEMENT
Who Completes? YOU, the employee.

Employee's Name:	Social Security No.:	DOB:	Gender

ADDRESS:	STREET	CITY/STATE	ZIP CODE

Local Union NO:	Your Phone No.: ( )_____-_____

Date of injury: _____ **Describe Injury**:_____

Is your condition work-related? · Yes · No

If Yes, Date Injury Reported to Employer? _____/_____/_____

Has a Workman's Comp Claim Been Filed? · Yes · No

If Yes, what is the outcome of your Claim? Approved/Pending/Denied

*if due to Work Comp or Subrogation, additional information may be requested by the Fund Office.

Authorization: For the purpose of evaluating my *eligibility for insurance and eligibility for benefits* under an existing policy/certificate including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim form, I hereby authorize the disclosure of the following information about me with the entities below. **Disclosure of Health Information** Health information may be disclosed by any health care provider, health plan or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes. ***Fraud Notice: Any person who knowingly and with intent to defraud any insurance company, files a statement of claim containing any materially false, incomplete or misleading information, is guilty of crime.*** **I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I have read the fraud notice included in this form.**

Employee's Signature:	**Date of Signature:**

Incomplete forms will not be returned. Do not return until all forms have been completed. It is the duty of the Employee filing Loss of Time Claim to ensure all required documents are completed and return to the Fund Office.

Fax: 901-758-3021, Upload: www.bams.bz, Mail: 661 N. Ericson Road, Cordova, TN 38018

Notice Regarding Days Payable: If your Doctor does not list a return to work date or a end date, we will extend benefits for a maximum of 6 weeks. If your medical leave continues, YOU are required to provide a Physician's Medical Continuation Form that list the extended end date.

End of Claim Part A

Part B: EMPLOYER'S STATEMENT

Who Completes? Your Store Manager or Human Resource

Employee's Name:	Social Security No.:
Date Employee was LAST present at work? _____/_____/_____	Employee's **Hourly Rate** of Pay at the time of Disability Period? $_____._____

Prior weekly hours (8 weeks prior to disability), Hours to INCLUDE any vacation time taken.
WK 1: _____ WK2:_____ WK3: _____WK4: _____WK5: _____ WK6: _____ WK7: _____WK8: _____ **Total: _____**
*Benefits are paid on the average hours worked PRIOR to the Disability Period.

Prior to the Disability Period, was the employee any of the following (please circle): Laid off / On Leave / Retired / Discharged / NONE

Is the employee's condition work-related? ☐ Yes ☐ No
If Yes, Date Injury Reported to Employer? _____/_____/_____
Has a Workman's Comp Claim Been Filed? ☐ Yes ☐ No
If Yes, what is the outcome of the Claim? Approved / Pending / Denied

Authorized Kroger Personnel (Store Management/Leadership) Your signature certifies you have verified the employee's hours worked, their hourly rate of pay and are approving any applicable time off that correlates with a Leave of Absence provided they meet the criteria as outlined in the Plan's SPD.

Incomplete forms will not be returned. Do not return until all forms have been completed. It is the duty of the Employee filing Loss

Full Name: (Authorized Employer)	Title:	Phone #:
Address:	City/State/Zip	Store #:
EMPLOYER SIGNATURE:	**DATE SIGNED:**	

of Time Claim to ensure all required documents are completed and return to the Fund Office.

Fax: 901-758-3021, Upload: www.bams.bz, Mail: 661 N. Ericson Road, Cordova, TN 38018

End of Claim Part B

Part C: PHYSICIAN'S STATEMENT
Who Completes? Your Doctor

Patient's Name	Patient's Social Security No.:

Please provide all applicable information requested about your patient. The information you share will be used in making a decision about your patient's claim for disability benefits.

First date of treatment for this condition: *(mm/dd/yyyy)* _____/_____/_____	**Most recent** date of treatment for this condition *(mm/dd/yyyy)* _____/_____/_____	***First Date of Disability*** *(mm/dd/yyyy)* _____/_____/_____

About your patient's prognosis

Have you advised your patient about when they can return to work?

☐ Yes *(Check all that apply.)*

☐ To regular occupation. On date *(mm/dd/yyyy)* _____/_____/_____ ☐ Full-time ☐ Part-time ☐ Modified duty

☐ To any other occupation. On date *(mm/dd/yyyy)* _____/_____/_____ ☐ Full-time ☐ Part-time ☐ Modified duty

☐ No *(Please explain.)*_____

What is the cause of your patient's symptoms? (*Check one.)*

☐ Injury ☐ Illness ☐ Pregnancy - Type of birth: *(Check one.)*

☐ Caesarean ☐ Natural birth ☐ Not yet delivered: Expected delivery date *(mm/dd/yyyy)* _____/_____/_____

Diagnosis/ICD-10 Primary Code: _____ Diagnosis/ICD-10 Secondary: _____

Is your patient's condition work-related? ☐ Yes ☐ No

Did you advise your patient to stop working? ☐ Yes On date *(mm/dd/yyyy)* _____/_____/_____ ☐ No

Has your patient been hospitalized for this condition? ☐ Yes On date *(mm/dd/yyyy)* _____/_____/_____ ☐ No

Name: (ATTENDING PHYSICIAN)		Phone #:	Degree of Specialty:	
Address:	City/State/Zip		Business/Practice Name:	TIN/EIN/NPI:

AUTHORIZED SIGNATURE OF PHYSICIAN

"I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief."

PHYSICIAN SIGNATURE: **DATE SIGNED:**

Incomplete forms will not be returned. Do not return until all forms have been completed. It is the duty of the Employee filing Loss of Time Claim to ensure all required documents are completed and return to the Fund Office.

Fax: 901-758-3021, Upload: www.bams.bz, Mail: 661 N. Ericson Road, Cordova, TN 38018

End of Claim Part C