INSTRUCTIONS FOR FILING AN OTJA CLAIM

Note that sickness/illness/disease/infections are NOT covered, nor is wear & tear/deterioration of muscles/body (as indicated as such by physician). An off the job, single, accident type incident (as indicated by the physician) must cause the injury. You cannot collect unemployment along with this benefit.

- ☐ **Review your claim and direct deposit forms carefully and gather banking document**
  - Be sure ALL information in Section A, B, and C is complete BEFORE sending this
- ☐ **Sign your claim form and the Direct Deposit Enrollment form**
  - The claim form must be signed by the ironworker, the local, and attending physician (not a chiropractor).
- ☐ **Include your contact information. Print Legibly or complete digitally (preferred)**
  - Ensure your address, **email address (required),** and phone number are legible
- ☐ **When the claim and the IMPACT Direct Deposit form are complete,** be sure to also attach a copy of a voided check/your own bank's direct deposit form, THEN send in all documents to IMPACT@BMGIWEB.COM
- ☐ **Verify that your claim form was submitted properly**
  Be sure the physician or the Local submits the fully completed claim form if they are sending it in. If the local section is not completed, ask your Dr. to send it to your local.
- ☐ **Check your email (and mail)**
  - BMGI will EMAIL (check spam folder) you if ADDITIONAL information is NEEDED.
  - EOBs/CLAIM DECISIONS are emailed Wednesdays from **awsrelay@bmgiweb.com Emails are secure so they must be opened within 24 hours of being sent**.
  - Year-end 1099 will be MAILED through the US Post Office.
- ☐ **If BMGI notifies you that info was requested from the doctor, contact him**
  - Be sure your physician's office promptly completes and returns requested info to BMGI
- ☐ **Apply FIRST for any Union, City, State (New Jersey, California, etc.) or Federal Government disability/loss of time benefits that you are eligible for**
  - BMGI needs proof of you being denied or approved in order to calculate your benefit
- ☐ **BMGI will ask your health plan to verify eligibility on the date of your injury**
  - Confirm you are eligible under your health plan at the time of your injury/accident

Email: IMPACT@bmgiweb.com (preferred)

Mail: IMPACT Off-the-Job Accident Plan
625 Enterprise Drive
Oak Brook, IL 60523

Phone/Fax: 630-828-7000

IMPACT Off-the-Job Accident Plan

WEEKLY TIME LOSS CLAIM FORM -See Instructions Page

625 Enterprise Drive • Oak Brook, IL 60523 • Phone 630-828-7000

Administered by Benefits Management Group, Inc. (BMGI)

RETURN COMPLETED FORM
IMPACT@bmgiweb.com or
Fax or Text 630-828-7000

ALL EOB'S/CLAIM DECISIONS are emailed from awsrelay@bmgiweb.com on Wednesdays. CHECK YOUR SPAM FOLDER

☐ Initial request for benefits ☐ Supplemental information on active time loss claim ☐ Check here if your address is new

SECTION A – PLEASE PRINT LEGIBLY TO BE COMPLETED BY THE IRONWORKER

IRONWORKER NAME	SOCIAL SECURITY NO. - -	BOOK NO.	DATE OF BIRTH	GENDER
HOME ADDRESS INCLUDING CITY – STATE - ZIP			LOCAL UNION NO.	
MOBILE PHONE NO.	EMAIL ADDRESS		ARE YOU RETIRED	

DATE OF INJURY/ACCIDENT _____ WERE YOU INTOXICATED WHEN THE INCIDENT OCCURRED? YES / NO

FULL DETAILS ON HOW AND WHERE THE INCIDENT HAPPENED _____

WERE YOU AT WORK WHEN INCIDENT OCCURRED? YES / NO HAVE YOU FILED FOR WORKERS' COMPENSATION BENEFITS? YES / NO

HAVE YOU FILED FOR UNEMPLOYMENT BENEFITS? YES / NO ARE YOU CURRENTLY RECEIVING UNEMPLOYMENT BENEFITS? YES / NO

WHAT IS THE DATE AND GROSS AMOUNT OF YOUR LATEST UNEMPLOYMENT CHECK _____

NAME OF YOUR DOCTOR _____ DOCTOR'S PHONE NO. _____

NAME AND ADDRESS OF HOSPITAL _____

DATE ENTERED HOSPITAL _____ DATE DISCHARGED _____

"I hereby authorize any Dentist, Physician, Hospital, Pharmacy, Insurance Company, Employer, Health Plan Administrator or Local Union Organization to release any information regarding the medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable including disability or employment related information concerning this claim to Benefits Management Group, Inc. or its authorized agent for the purpose of validating and determining benefits payable in connection with this claim. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request."

SIGN HERE► _____ _____

IRONWORKER SIGNATURE DATE SIGNED

SECTION B – PLEASE PRINT LEGIBLY TO BE COMPLETED BY ATTENDING PHYSICIAN (MD) - NOT A CHIROPRACTOR

PATIENT'S NAME	AGE	IS PATIENT PREGNANT? YES / NO
DIAGNOSIS (**ICD10) CODES**		IF HOSPITALIZED, DATE OF ADMISSION
IS CONDITION RELATED TO EMPLOYMENT? YES / NO	Is this an "ACCIDENTAL" INJURY	YES / NO
DESCRIBE THE ACCIDENT type incident AND also the INJURY:		
DATE FIRST CONSULTED FOR THIS CONDITION:	IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? NEXT APPOINTMENT DATE: _____	YES / NO
IS PATIENT **UNABLE** TO PERFORM THE DUTIES OF AN IRONWORKER WITH THIS CONDITION? YES / NO		
PATIENT IS CONTINUOUSLY UNABLE TO WORK FROM: _____ **TO**: _____		**TBD IS NOT ACCEPTABLE FOR ENDING DATE**

DATE	PHYSICIAN'S NAME (PLEASE PRINT)	SIGNATURE **X**	DEGREE
STREET ADDRESS INCLUDING CITY – STATE – ZIP		PHONE	

PHYSICIAN, PLEASE COMPLETE THIS SECTION AT FOLLOW UP APPOINTMENT
DATE OF FOLLOWUP: _____

IF PATIENT IS RELEASED TO RETURN TO WORK, PLEASE PROVIDE THE DATE S/HE MAY RETURN TO WORK:	IF PATIENT IS **NOT** RELEASED TO RETURN TO WORK, PLEASE PROVIDE THE DATE OF THE NEXT APPOINTMENT:
PHYSICIAN SIGNATURE	

SECTION C – PLEASE PRINT LEGIBLY TO BE COMPLETED BY THE LOCAL UNION AND/OR WELFARE PLAN

LOCAL UNION NO: _____ REGION/RAB: _____ HOURLY RATE: $_____ BASIC GROSS WEEKLY EARNINGS: $_____

WAS IRONWORKER ELIGIBLE ON HEALTH PLAN ON DATE OF INCIDENT? YES / NO	IRONWORKERS LAST EMPLOYER:	
LOCATION/STATE OF LAST JOBSITE:	DATE LAST WORKED:	DATE RETURNED TO WORK, IF KNOWN:
DOES THIS LOCAL/HEALTH PLAN OFFER A LOSS OF TIME BENEFIT? YES / NO	DOES THIS LOCAL/HEALTH PLAN OFFER MATERNITY LEAVE? YES / NO	
WEEKLY AMOUNT FROM UNION: $	WEEKLY AMOUNT FROM HEALTH PLAN: $	WEEKLY AMOUNT FOR MATERNITY: $
ANY OTHER L.O.T. DETAILS:		

PRINT NAME OF SIGNER _____ PHONE NO. _____ EMAIL _____

SIGN HERE► _____ _____

AUTHORIZED REPRESENTATIVE DATE SIGNED

Benefits Management Group, Inc.
https://www.bmgiweb.com/IMPACT

I.M.P.A.C.T BENEFIT PLANS
c/o Benefits Management Group, Inc. (BMGI)
625 Enterprise Drive ♦ Oak Brook, Illinois 60523
IMPACT@bmgiweb.com Phone/Fax:
630.828.7000

I.M.P.A.C.T. REINFORCE OUR FUTURE
https://www.impact-net.org

Direct Deposit Agreement Form

LAST NAME	FIRST NAME	LAST 4 NUMBERS OF SOC. SEC. NO.
HOME ADDRESS INCLUDING CITY – STATE - ZIP		LOCAL UNION NO.
MOBILE PHONE NO.	EMAIL ADDRESS	
BANK NAME	BANK ACCOUNT TYPE ☐ CHECKING ☐ SAVINGS	
BANK ROUTING NO.	BANK ACCOUNT NO.	

In signing this form, I authorize my payment to be sent to the financial institution named above, and if necessary, to electronically debit my account to correct erroneous entries. I am an authorized signer on the account and will notify the IMPACT Office in advance of closing this account.

This authority is to remain in effect until my benefits with I.M.P.A.C.T. OTJA or Maternity Provision Plan cease.

The completed and signed form, along with one of the below other required bank documents, may be returned via email, fax, or mailed to the address listed above.

_____ _____ / _____ / _____
Signature **Date**

YOU MUST Attach a Voided Check or Direct Deposit Form printed by your bank