INSTRUCTIONS FOR FILING A MATERNITY CLAIM

For Paid Maternity Leave to commence prior to delivery/birth, the Member must be deemed unable to work by their medical doctor. A separate Physician's note must be submitted with this claim form and it must indicate that the Member is not able to work AS AN IRON WORKER DUE TO PHYSICAL LIMITATIONS arising from the pregnancy. Paid leave can't begin until at least the 4th month of pregnancy. This cumulative pre-delivery benefit may be intermittent and may not exceed 26 weeks (6 months). After 26 weeks, the paid benefit will stop regardless of whether the Member is able to return to work or not. You CANNOT collect unemployment along with this maternity benefit.

☐ **Review your claim form carefully before you or your doctor send it in**
- Be sure **all** information in **Section A, B, and C is complete and a Dr. note is sent**

☐ **Sign your claim form and the Direct Deposit Agreement (and attach a voided check)**
- The claim form must be signed by the ironworker, the attending physician, **and the Local Union representative before you or the doctor sends it in**

☐ **Verify that your claim form and all other forms/notes were submitted**
- If they are sending it on your behalf, be sure the physician or the Local submits only a fully **completed** claim form, Dr. note, and **both types of banking documents**.

☐ **Include your contact information. Print Legibly or complete digitally (preferred)**
- Ensure your address, **email address (required),** and phone number are legible

☐ **Check your email (and mail)**
- BMGI will EMAIL (check spam folder) you if ADDITIONAL information is NEEDED.
- EOBs/CLAIM DECISIONS are emailed Wednesday from **awsrelay@bmgiweb.com Emails are secure so they must be opened within 24 hours.**
- Year-end 1099s will be MAILED through the US Post Office.

☐ **If BMGI notifies you that info was requested from the doctor, contact them**
- 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 will need this information in order to calculate your benefit

☐ **Ask your health plan to verify eligibility on the date of your injury**
- Confirm you are eligible under your health plan as of the start of your pregnancy.

EMAIL: IMPACT@bmgiweb.com	Mailing Address: 625 Enterprise Drive Oak Brook, IL 60523
Phone/Fax: 630-828-7000	

IMPACT Maternity Leave Program

WEEKLY TIME LOSS CLAIM FORM-SEE INSTRUCTIONS

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
HOME ADDRESS INCLUDING CITY – STATE - ZIP			LOCAL UNION NO.
MOBILE PHONE NO.	EMAIL ADDRESS		

EXPECTED DATE OF BIRTH:	
ARE YOU REQUESTING LEAVE PRIOR TO YOUR EXPECTED BIRTH DATE? ☐ YES ☐ NO	IF YES, REQUESTED LEAVE DATE:
REASON FOR REQUESTED LEAVE:	
NAME OF YOUR DOCTOR:	DOCTOR'S PHONE NUMBER:
IF YOU ARE HOSPITALIZED OR HAVE DELIVERED, PLEASE LIST 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**		
PATIENT'S NAME	AGE	IS PATIENT PREGNANT? ☐ YES ☐ NO	
DIAGNOSIS (ICD10) CODES:		IF HOSPITALIZED, DATE OF ADMISSION:	
DATE FIRST CONSULTED FOR THIS PREGNANCY:	IS PATIENT STILL UNDER YOUR CARE FOR PRE- POST-NATAL CARE? ☐ YES ☐ NO NEXT APPOINTMENT DATE:_____		
IS PATIENT **UNABLE** TO PERFORM THE DUTIES OF AN IRONWORKER WITH THIS CONDITION? ☐ YES ☐ NO			
PATIENT IS CONTINUOUSLY UNABLE TO WORK FROM: _____ TO: _____			
DATE	PHYSICIAN'S NAME (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	

IMPORTANT: SEPERATE DR NOTE IS NEEDED STATING THE PATIENT IS DISABLED FROM WORKING AS IRONWORKER **DUE TO MATERNITY**

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 MATERNITY LEAVE? ☐ YES ☐ NO	IF YES, 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