Municipal Employees' Annuity and Benefit Fund of Chicago
A Pension Trust Fund if the City of Chicago
321 N. Clark Street, Suite 700, Chicago, Illinois 60654
Telephone: 312 -236-4700 Fax: 312-527-0192
www.meabf.org

Dear Member:

Enclosed are the forms you must complete and a list of required documents that you need to submit in order for us to process your application for Duty Disability benefits.

Forms to be completed (enclosed)

Authorization to Disclose Health and Employment Related Information
Disability Application

Required documents to be returned with the forms

- Copy of Mercy Works Statement from your first visit AND
- Copy of most recent Mercy Works Statement (If you are still seeing Mercy Works) OR
- Last Statement (if you have been released to return to work)
  If you are not being treated by Mercy Works, please provide:
  Medical Examiner's Certificate from your attending physician
- Copy of Occupational Injury Report
- Birth Certificates for Children under the Age of 18
- Concentra Services - Patient Information
- Concentra Services - Authorization for Disclosure of Protected Health Information (PHI) HIPAA Release

Important Information

- In order to begin the processing of your disability benefits, your application must be complete and all required documentation provided.
- **Upon the Fund's receipt of your completed Disability application and medical form, you are required to make an appointment with a local Concentra provider for approval of this benefit. This should only be done once we have your completed application back in our office. Therefore, please be sure to list an active phone number and email address on the application.**
- Duty disability cannot begin until you have been approved by and are receiving Workers' Compensation benefits.
- If you become separated from service for any reason, or are released to return to work, or return to work while receiving disability benefits, you are required to notify this Fund immediately.
- Disability payments are paid while you are disabled and while you are an employee of the City of Chicago or Board of Education. If you become terminated or if you resign, all disability payments stop. If payments are made after such date in error, they will be deducted from any benefits we pay you.

Enclosed please find a listing and map of all Chicago Concentra locations. If you are physically unable to appear at any of these locations, kindly notify the Fund.

If you have any questions regarding the application process or your disability benefits, please contact Scott Walters at (312) 236-4700 Ext 2123.

Disability Department
Additional information regarding disability benefits can be found on our website at www.meabf.org

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Authorization to Disclose Health and Employment Related Information

Name of Member (First Name, Middle Initial, Last Name) **Last 4 digits Social Security Number or MEABF ID#**

Daytime Phone Evening Phone

Address

City State ZIP

Authorization to Release Information

I authorize the disclosure of my protected health information, including but not limited to, medical histories, diagnoses, examination reports, chart notes, testing and test results, X-rays, operative reports, lab and medication records, prescriptions, and any other records relating to the prognosis, treatment or diagnosis of any physical, mental, psychological or psychiatric condition, to the Municipal Employees' Annuity and Benefit Fund of Chicago (MEABF) or its representative, for the sole purpose of determining my physical or mental condition, illness, or disability and my right, if any, to benefits under the Illinois Pension Code (40 ILCS 5/8 et seq). I understand that any information about me disclosed pursuant to this Authorization will be used by MEABF for the administration of its duties under the Illinois Pension Code. I understand that this Authorization and submission of the requested information is authorized pursuant to Section 8-162 and Section 8-163(a) of the Illinois Pension Code and that failure to supply the information requested may result in MEABF being unable to make a determination regarding my benefit status.

This Authorization applies to any and all health and/or medical related information about me in the possession of any health care provider, health plan, insurance company, employer or plan administrator, government agency, or organization or entity administering a benefit program.

I understand that if my protected health information is disclosed to someone who is not required to comply with federal privacy protection regulations, that information may be re-disclosed and would no longer be protected.

I understand that I have a right to revoke this Authorization at any time. My revocation must be in writing by a letter directed to the MEABF Disability Department. I am aware that my revocation is not effective to the extent that persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this Authorization. Unless cancelled by me in writing, this Authorization shall be valid for four (4) years from the date shown below. A photocopy of this Authorization shall be as valid as the original. I understand that I may request a copy of this Authorization at any time.

I also authorize the disclosure of any and all personnel and other employment-related records on file with any of my present or future employers which relate to my job duties, work performance, and other work-related issues including, but not limited to, attendance and sick leave records and records of administrative and judicial action arising out of, or related to, my past and present employment. I understand that it is my responsibility to notify the MEABF if I have returned to work, or have left the employment of my employer. I also understand that I must notify MEABF if I assume other employment while in receipt of a disability benefit in accordance with Section 8-163(d).

Signature of Member **Date (mm/dd/yyyy)**

Email Address of Member

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OFFICE USE ONLY – Payment

Start Date	End Date	Daily Rate

APPLICATION FOR DISABILITY BENEFITS - DUTY

(FOR DISABILITY RESULTING FROM INJURY INCURRED IN THE PERFORMANCE OF DUTY)

SECTION 1 – MEMBER INFORMATION (Please Print or Type)

NAME (FIRST, MI, LAST)	DATE OF BIRTH (MM- DD- YYYY)	SOCIAL SECURITY NUMBER (LAST 4 DIGITS)
ADDRESS		CITY, STATE, ZIP
PRIMARY PHONE NUMBER ( )	SECONDARY PNONE NUMBER ( )	E-MAIL ADDRESS
JOB TITLE	DEPARTMENT	
EMERGENCY CONTACT (FIRST, MI, LAST)		EMERGENCY CONTACT PHONE NUMBER ( )
LIST NAME, DATE OF BIRTH, SOCIAL SECURITY NUMBER (LAST 4 DIGITS) OF EACH OF YOUR CHILDREN UNDER AGE 18 (BIRTH CERTIFICATES REQUIRED)		
CHILD NAME (FIRST, MI, LAST)	DATE OF BIRTH (MM- DD- YYYY)	SOCIAL SECURITY NUMBER (LAST 4 DIGITS)

SECTION 2 – NATURE OF DISABILITY

DATE OF INJURY (MM- DD- YYYY)	LAST DATE WORKED (MM- DD- YYYY)	LAST DATE PAID (MM- DD- YYYY)
HAVE YOU BEEN RELEASED TO RETURN TO WORK? ☐ NO ☐ YES IF **YES,** DATE (MM-DD-YYYY) _____		
DESCRIBE ACCIDENT / ILLNESS THAT CAUSED DISABILITY		
WAS AN ACCIDENT REPORT COMPLETED WITH YOUR EMPLOYER? ☐ YES ☐ NO		
HAVE YOU FILED A CLAIM WITH WORKERS' COMPENSATION FOR THIS INJURY? ☐ YES ☐ NO		
STATUS OF WORKERS' COMPENSATION CLAIM (CHECK ALL THAT APPLY) ☐ PENDING ☐ APPROVED ☐ DENIED ☐ APPEALED		

SECTION 3 – CERTIFICATION

I authorize the Municipal Employees' Annuity and Benefit Fund of Chicago to have access to all records needed to Properly process this application.

MEMBER SIGNATURE X _____ DATE ____/____/_____

WITNESS SIGNATURE X _____ DATE ____/____/_____

PRINT WITNESS NAME _____ PHONE NUMBER (____)_____

Be advised that under Illinois law (P.A. 97-0651) MEABF is required to report to the state's Attorney for investigation any reasonable suspicion of any falsified statement or record or any fraudulent claim involving the MEABF. Under State law a person convicted of fraud may be subject to a fine of not more than $25,000 or imprisonment for not more than five (5) years or both.

ORIGINAL DOCUMENT REQUIRED. DO NOT FAX

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Tiffany Junkins, Executive Director

OFFICE USE ONLY

	Start Date	Last Ext. Date	Daily Rate
Ext			

MEDICAL EXAMINER'S CERTIFICATE FOR DISABILITY BENEFITS - DUTY

SECTION 1 – TO BE COMPLETED BY EMPLOYEE (Please Print or Type)

NAME (FIRST, MI, LAST)	DATE OF BIRTH (MM-DD-YYYY)	SOCIAL SECURITY NUMBER (LAST 4 DIGITS)
JOB TITLE	DEPARTMENT	
DESCRIPTION OF DUTIES		
MEMBER SIGNATURE X _____	**DATE** _____ / _____ / _____	

SECTION 2 – TO BE COMPLETED BY PHYSICIAN

In an effort to ensure appropriate eligibility for disability benefits, we are evaluating the medical evidence and related information on the above patient. Please assist us by completing, signing, and returning the following information to the Fund office.
THE FOLLOWING REQUESTED INFORMATION MUST BE COMPLETED IN ITS ENTIRETY OR THE FORM WILL BE RETURNED FOR PROPER COMPLETION. (We do not accept faxex or copies of this form. Original form must be returned.)

DATE OF MOST RECENT EXAM	DATE OF INITIAL EXAM
DIAGNOSIS	
HOW DOES THIS DIAGNOSIS PROHIBIT THE PATIENT FROM PERFORMING THE DUTIES OUTLINED IN THE THEIR DESCRIPTION OF DUTIES?	
ARE THERE ANY OTHER FUNCTIONAL LIMITATIONS OR PHYSICAL RESTRICTIONS IMPEDING THE PATIENT'S ABILITY TO PERFORM HIS OR HER DUTIES?	
IS CONDITION DUE TO INJURY ARISING OUT OF PATIENT'S EMPLOYMENT?	☐ YES ☐ NO
IF SURGERY IS/WAS NECESSARY, SURGERY DATE _____ / _____ / _____ TYPE OF SURGERY:	
DUTY DISABILITY: WAS THIS DISABILITY THE RESULT IN ANY MEASURE OF A PHYSICAL CONDITION OR DISEASE WHICH EXISTED AT THE TIME OF INJURY? ☐ YES ☐ NO	
TREATMENT PLAN	
IS PATIENT NOW ABLE TO RETURN TO WORK IN FULL DUTY CAPACITY OR WITH WORK RESTRICTIONS? ☐ YES, FULL DUTY ☐ YES, WITH RESTRICTIONS IF **YES**, DATE _____ / _____ / _____ ☐ NO IF **NO,** ESTIMATED DURATION OF DISABILITY _____	
PHYSICIAN NAME (FIRST, MI, LAST)	DEGREE / SPECIALTY
ADDRESS	CITY, STATE, ZIP
PHONE NUMBER ( )	FAX NUMBER ( )

I hereby certify that the information provided above is true and accurate to the best of my knowledge.

PHYSICIAN SIGNATURE X _____ DATE _____ / _____ / _____

Employer Services-Authorization For Disclosure of Protected Health Information (PHI) HIPAA Release

I authorize Concentra to use and disclose protected health information (PHI) from the record(s) of:

Patient's Name: _____ Birthdate: _____

Address: _____

Purpose of Disclosure

☐ Occupational Injury ☐ Occupational Non-Injury ☐ Other

Confirmation of Who May Receive Copies of Your Records

Employer or Entity Name: _____

Address: _____ City: _____ St: _____ Zip: _____

Fax Number: _____ Confirmation Telephone Number: _____

In Connection With This Authorization:

- I am aware that copies of records for services rendered on _____ (date of service) and subsequent related visits containing PHI which may include the results of tests or evaluations, including diagnosis, medical history, transcription notes, tests; and evaluations performed that my treating clinician(s), employer, prospective employer, or third-party entity has ordered or requires.
- I give Concentra authorization to release to my employer, insurance company, and/or their representatives any medical information, including any psychotherapy notes, psychiatric information, sexually transmitted diseases, alcohol, and drug abuse (;) and/or HIV/
- AIDS status, which is obtained as part of the evaluation and/or treatment for this work-related injury/illness, or employment-related examination.
- I understand that if the person or entity that receives the above information Is not a health care provider or health plan covered by federal privacy regulations, the Information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
- I understand that I may revoke this authorization at any time, except to the extent that action has already been taken by Concentra, by providing a written request to the Center where my care was provided.
- I understand that Concentra may not deny treatment If I do not complete this authorization form but may deny services when the services are only to create PHI for disclosure to a third party.
- I have a right to not sign this authorization or to limit the information I authorize to be disclosed to the minimum necessary, however, refusal to sign this authorization or to limit disclosure of my PHI may violate a condition of employment or prospective employment.
- I may revoke this authorization at any time, but I must po so by submitting a written notice to the Concentra center where I received services. However, if I am here for a work-related visit that is subject to Workers' Compensation, under some state laws I am not allowed to revoke this authorization.
- I understand that this authorization expires one year from the date of execution, unless revoked in writing, or a shorter expiration date Is required by applicable state law.

I have a right to receive a copy of this authorization.

_____ OR _____

Signature of Patient's Representative/Date: _____ Patient's Signature/Date: _____

_____ _____

Printed Name of Patient's Representative Explanation of your legal right to sign for Patient

For HIPAA questions related to this form, please contact the Concentra Privacy Office at 1-800-819-5571

Privacy-Occupational Authorization-ENG 032421

Employer Services Patient Information

About You
Reason for Today's Visit

☐ Injury care ☐ Physical exam ☐ DOT (CDL) certification ☐ Drug screen ☐ Other: _____

Social security number or Military DBN_____ Date of birth (MM/DD/YYYY): _____

Last name: _____ First name: _____ Middle initial: _____

Address: _____ Apartment number: _____ City: _____ State: ___ ZIP: _____

Horne phone: _____ Work phone: _____ Cell phone: _____

Birth Sex: ☐ Male ☐ Female **Gender:** ☐ Male ☐ Female ☐ Non-binary ☐ Single ☐ Married

Email address: _____ Concentra may send a detailed email: ☐ Yes ☐ No

For security of your records, all emails containing protected health information (PHI) are sent encrypted,

*** Consent to Receive Text Messages:** By providing your personal cell phone number to Concentra, you are agreeing to receive text messages from Concentra, its related companies, and/or vendors regarding medical services. Your consent to receive such communication is not a condition of the provision of medical services.

Signature: _____ Date: _____

About Your Employer
Employer Requesting Services

Company name: _____ Location/store number: _____

Address: _____ Suite number: _____ City: _____ State: _____ ZIP: ___ _

Is your employment arranged through a temporary hire agency? ☐ Yes ☐ No

Name of agency: _____ Agency phone: _____

Notice of Privacy Practices

Your name and signature below indicates that you have been made aware of Concentra's Notice of Privacy Practices (NOPP) on the date indicated. You understand that the NOPP is posted in the center and a copy will be provided to you if you request it If this is your first date of service with Concentra, please indicate this to the front desk receptionist and he/she will provide you a copy of the NOPP. If you have any questions regarding the information in Concentra's Notice of Privacy Practices, contact Concentra's Privacy Office at 800-819-5571 or privacyoffice@concentra.com.

Name: (please print) _____ Date notice received: _____

Signature: _____ Date: _____

Consent

Please read and sign both sections below UNLESS you are here for a Department of Transportation drug screen or breath alcohol test only (no physical).

The information provided is correct to the best of my knowledge I will not hold Concentra, its health provider, or its employees responsible for any errors or omissions that I may have made in completing the information on this form.

Signature: _____ Date: _____

I give permission to Concentra to perform the following services that the pl1ysicians and other non-physician providers and assistants may deem to be necessary: (a) medical, surgical, and diagnosis (e.g., including but not limited to x-rays, blood draws, and laboratory tests) processes, treatments, and procedures; (b) administration of injections, medications, and immunizations (with immunizations to occur after my receipt of any applicable vaccine Information statements (''VIS'' or "VISs"); and (c) completion of medically appropriate tests for communicable and other diseases: and (d) completion of a pelvic examination, if medically appropriate. I further understand that by counseling to receive a vaccine, I am authorizing Concentra to release my Immunization information lo the applicable state immunization registry.

Signature: _____ Date: _____

CHICAGO LOCATIONS

1. Bedford Park
5015 W 65th St
Bedford Park, IL 60638
Mon-Fri: 8 am -5 pm
Ph: 708.924.8000
Fx: 708.924.8008

2. Bellwood
2615 W. Harrison St.
Bellwood, IL 60104
Mon - Fri: 7 am - 7 pm
Ph: 708.493.0299
Fx: 708.493.0594

3. Bloomingdale
211 E. Army Trail Rd.
Bloomingdale, IL 60108
Mon-Fri: 7 am - 8 pm
Ph: 630.582.8946
Fx: 630.582.0969

4. Bridgeview
8755 S. Harlem Ave.
Bridgeview, IL 60455
24 Hours, 7 Days a Week
Ph: 708.430.2295
Fx: 708.430.2372

5. Chicago Ashland Ave
(Ashland Ave at 1-55)
3145 S. Ashland Ave.
Suite 110
Chicago, IL 60608
Mon - Fri: 7 am -10 pm
Ph: 773.254.5516
Fx: 773.254.5518

6. Chicago Downtown
614 W. Monroe St.
Chicago, IL 60661
Mon - Fri: 8 am - 5 pm
Ph: 312.258.0700
Fx: 312.258.0705

7. Chicago Midway
6500 West 65th St.
Chicago, IL 60638
Mon - Fri: 7am - 7 pm
Ph: 708.496.1515
Fx: 708.496.3433

8. Chicago Pullman District
900 E. 103rd St.
Chicago, IL 60628
Mon - Fri: 8 am -5 pm
Ph: 773.468.2963
Fx: 773.468.2975

9. Chicago River West
1030 W. Chicago Ave.
Chicago, IL 60642
Mon - Fri: 7 am- 10 pm
Sat: 8 am - 5 pm
Ph: 312.243.1574
Fx: 312.243.1698

10. Chicago West Loop
1230 W. Lake St.
Chicago, IL 60607
Mon - Fri: 8 am - 5 pm
Ph: 312.666.0028
Fx: 312.666.5214

11. Darien
7421 South Cass Ave.
Darien, IL 60561
Mon- Fri: 8 am- 8 pm
Ph: 630.286.5300
Fx: 630.986.1096

12. Elk Grove Village
1830 Jarvis Ave.
Elk Grove Village, IL 60007
Mon - Fri: 8 am -5 pm
Ph: 847.952.1180
Fx: 847.952.1183

13. Franklin Park
10137 W. Grand Ave.
Franklin Park, IL 60131
Mon - Fri: 7 am-10 pm
Sat: 8 am - 5 pm
Ph: 847.451.7590
Fx: 847.451.7608

14. Hammond
6423 Columbia Ave, U
Hammond, IN 46320
Mon-Fri: 7 am- 8pm
Ph: 219.937.3632
Fx: 219.937.4715

15. Morton Grove
8125 River Dr.
Suite 102
Morton Grove, IL 60053
Mon - Fri: 8 am - 5 pm Ph: 847.470.1720
Fx: 847.470.1723

16. Schiller Park
4200 N. Mannheim Rd.
Schiller Park, IL 60176
Mon -Fri: 8 am -5 pm
Ph: 847.801.5170
Fx: 847.801.5176

17. Wheeling
544A W. Dundee Rd.
Wheeling, IL 60090
Mon - Fri: 7 am - 9 pm
Ph: 847.419.6974
Fx: 847.419.6982

- Work-related injuries receive immediate triage assessment.
- Pre-placement and DOT exam forms are provided, or you may use other DOT approved MER and/or MEC forms.
- No contract is required when working with Concentra. Our fees are competitive and adhere to the applicable state workers' compensation fee guidelines.
- Visit concentra.com/our-locations for a list of locations and driving directions

CHICAGO LOCATIONS