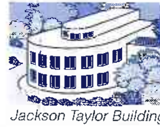
Steamship Trade Assn.
International Longshoremen's Assn.
Pension Trust Fund ■ Benefits Trust Fund
Severance & Annuity Trust Fund


Jackson Taylor Building

Barbara Rock
Claims Representative

Holabird Business Park, 6610 Tributary St., Balto., MD 21224-6514
☎ (410) 633-9311
FAX (410) 633-2189
email: brock@staila-balt.com

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Jackson Taylor Building

Sherri Frieze
MIS Manager

Holabird Business Park, 6610 Tributary St., Balto., MD 21224-6514
☎ (410) 633-9311
FAX (410) 633-2189
email: sfrieze@staila-balt.com

WEBSITE FOR LOCAL BALTIMORE BENEFITS:
STAILAFUNDS.COM

S.T.A. - I.L.A. OF BALTIMORE BENEFITS FUND
HOLABIRD BUSINESS PARK
6610 TRIBUTARY STREET
BALTIMORE, MD 21224-6514
(P) 410-633-9311 (F) 410-633-2189

ACCIDENT & SICKNESS (A&S) CLAIM FORM

YOUR A&S PAPERWORK MUST BE COMPLETED AND SUBMITTED WITHIN 90 DAYS OF YOUR ILLNESS OR INJURY. FAILURE TO COMPLETE THIS FORM WILL DELAY YOUR PAYMENT.

FORMS THAT ARE ALTERED WITH SCRATCH OUTS OR WHITE OUT WILL NOT BE ACCEPTED.

INSTRUCTIONS:

MEMBER MUST COMPLETE AND SIGN SIDE 1.

DOCTOR MUST COMPLETE AND SIGN SIDE 2.

When completing blocks 4 & 5, all dates must be specific. If the "return to work" date can not be determined, then please give the date of the next re-evalution.

PLEASE PRINT

Port Number ________________ Date of Birth ________________ SS# ________________

Name ______________________________ Email Address ______________________________

Home Address ____ Phone # ____________

City ______________________________ State ________ Zip Code ____________

Local __________ Name of Employer ______________________________

Nature of disability ____

Is disability due to an injury? No ____ Yes ____ Date injury occurred ________________

How and where did the injury happen? ____

Were you injured while in employment of a company outside the longshore industry? No ____________

If yes, what company were you employed with? Yes ______________________________

When did you become totally disabled so you could not work? Date ______________________________

When was your last day worked? ____

Have you filed a Workmen's Compensation claim? ____

Have you applied for Unemployment Compensation? ____

IF ADMITTED TO THE HOSPITAL, PLEASE SUBMIT HOSPITAL PAPERWORK WITH THIS FORM.

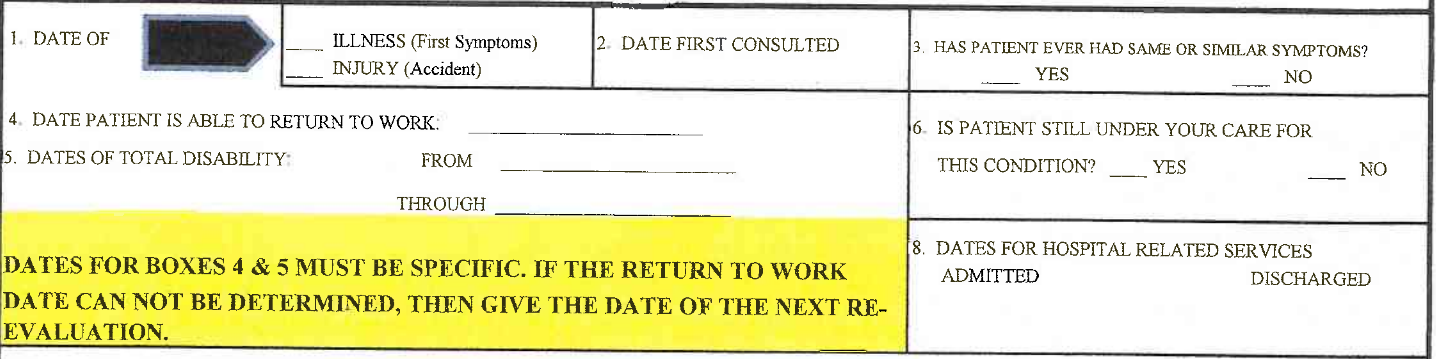
ALL ANSWERS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

MEMBER SIGNATURE ______________________________ **DATE** ______________

Patient's Name _______________ Date of Birth _______________

Patient's Address _______________

PHYSICIAN INFORMATION



1. DATE OF	____ ILLNESS (First Symptoms) ____ INJURY (Accident)	2. DATE FIRST CONSULTED	3. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ____ YES ____ NO

4. DATE PATIENT IS ABLE TO RETURN TO WORK: ____________________

5. DATES OF TOTAL DISABILITY: FROM ____________________ THROUGH ____________________

6. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ____ YES ____ NO

DATES FOR BOXES 4 & 5 MUST BE SPECIFIC. IF THE RETURN TO WORK DATE CAN NOT BE DETERMINED, THEN GIVE THE DATE OF THE NEXT RE-EVALUATION.

8. DATES FOR HOSPITAL RELATED SERVICES ADMITTED DISCHARGED

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY - RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBER OR DX CODE.

1.

2.

3.

4.

A DATE OF SERVICE FROM THRUOGH	B PLACE OF SERVICE	C DIAGNOSIS CODE	D CPT CODE	E FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN

I CERTIFY THAT I PERSONALLY RENDERED THE SERVICES DESCRIBED ABOVE

SIGNATURE OF PHYSICIAN OR SUPPLIER DATE

PROVIDER'S TAX I.D. #

PHYSICIAN OR SUPPLIER'S NAME, ADDRESS, CITY, STATE, ZIP CODE and PHONE NUMBER

PLACE OF SERVICE

1. INPATIENT HOSPITAL
2. OUTPATIENT HOSPITAL
3. DOCTORS OFFICE
4. PATIENTS HOME
5. DAY CARE FACILITY (PSY)
6. NIGHT CARE FACILITY (PSY)
7. NURSING HOME
8. SKILLED NURSING FACILITY
9. AMBULANCE

A. OTHER LOCATION
B. INDEPENDENT LABORATORY
C. OTHER MEDICAL/SURGICAL FAC

Dear Member:

A & S payments are **TAXABLE INCOME** and **you will** receive a W-2 for your A & S earnings. By law we must withhold Social Security and Medicare Taxes. **It is not mandatory for us to withhold federal or state taxes, but since these monies are taxable,** we are giving you the option to request federal and/or state taxes to be withheld from your A & S payment.

Please complete the form below and return to:

STA-ILA Benefits Fund
Holabird Business Park
6610 Tributary Street
Baltimore, MD 21224
ATTN: Barbara Rock

__________ I choose not to have Federal Taxes withheld.

__________ I chose not to have State Taxes withheld.

__________ I choose to have Federal Taxes withheld.
If you chose to withhold Federal Taxes, you must withhold a minimum of $20.00/wk.

__________ I chose to have State Taxes withheld.
If you chose to withhold Maryland Taxes, you must withhold a minimum of $14.00/wk

______________________________ ______________
MEMBER SIGNATURE DATE

Thank you,
Barbara Rock

HIPAA AUTHORIZATION FORM

PATIENT AUTHORIZATION FOR SPECIFIC DISCLOSURE
OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________________________

I, the undersigned, hereby authorize ______________________________ ("Provider") to disclose certain information (described below) about me to the S.T.A. Benefits Fund ('the Plan") for purposes of collecting Accident and Sickness (A&S) pay under the terms of the Plan.

The Provider is hereby authorized to disclose the following protected health informationto any representative of the Plan, including its employees, agents, counsel, and consultants: name, birth date, dates of service, diagnosis, treatment records, and length of disability.

This Authorization shall expire one (1) year from the date I last receive A&S benefits.

I have read and understood the following statements about my rights:

I may revoke this authorization at any time prior to its expiration date with regard to any or all persons or organizations identified on this form by notifying the recipient in writing, but the revocation will not have any effect on any actions that took place before the revocation. I may see and copy the information described on this form if I ask for it in writing. I am not required to sign this form to receive my health care benefits, including enrollment, treatment or payment of benefits.

I have read and understand the terms of this Authorization, and I agree to those terms.

__________________________   ______________
Signature of Patient   Date

____
Printed Name of Patient

A signed copy of this Authorization must be provided to the patient and attached to the patient's medical record. A copy of this Authorization is as effective as the original.

Please verify the following information:

Provider: ______________________________

Patient's Name: ______________________________

Patient's D.O.B. ______________________________

Date of service: ______________________________

Diagnosis: ______________________________

Length of Disability: ______________________________

__________________________________   ______________
Provider's Signature   Date