IBEW Local 613 and Contributing Employers Family Health Plan

REPORT OF CLAIM TO:

IBEW Local 613 Family Health Plan
c/o National Employee Benefits Administrators, Inc.
2010 N.W. 150th Avenue, Suite 100 • Pembroke Pines, FL 33028
Toll Free - 1.800.922.1613 • Fax - 1.954.266.2079

STATEMENT OF DISABILITY

PART A: TO BE COMPLETED BY THE PARTICIPANT CLAIMING BENEFIT FOR SELF

MARITAL STATUS
☐ Single
☐ Married Date _____
☐ Divorced Date _____
☐ Widowed Date _____

Full Name of Participant _____ Date of Birth _____ Sex _____
(Print)

Home Address _____
(No & Street) (City) (State) (Zip Code)

Phone No. & Area Code _____ Participant's Social Security No. _____ Local Union No. _____

Name of Company where you are employed _____

Is claim for a job related injury or illness? Yes ☐ No ☐ If yes have you filed for Workmen's Compensation? Yes ☐ No ☐

Date Disability began _____ Date Last Worked _____ Is any part of this disability due to your job? Yes ☐ No ☐

Worker's Compensation Insurance Company Information:

Name of Insurance Company _____ Policy No. _____

Address of Insurance Company _____ Cert. No. _____

Is the claim the result of an accident ? Yes ☐ No ☐ If yes, answer the following:

a. Where did the injury occur? _____ Date and Hour _____

b. What was the Partcipant doing when the injury occurred? _____

c. Describe the injury: Tell how it happened _____

_____

The above answers are true and complete according to the best of my knowledge and belief. I authorize any employers, insurance company, dental / medical prepayment plan, employee welfare benefit (including the Trust), service organization, physician, practitioner or other person and hospital, including the Veteran's Administration or other Institution, to relase or, obtain any medical / dental or benefit information that may be required to establish or support the validity of this claim, and further authorize said company, person or organization (including the Trust) in its discretion, to disclose to any other person company organization so requesting any of my personal dental / medical or claim information obtained in any case study or claim review. A copy of this authorization shall be as the original. I also acknowledge the subrogation right of the Plan, and additionally agree to repay any sums expended by the Plan for injury or sickness from caused or resulting from the intentional acts or negligence of another party or source. Additionally, should I receive any payments persuant to this statement which I am presently or may become ineligible to receive, I agree to return same, and to the Plan's imposition of a reduction in credit hours that may have been afforded/credited to me as a consequence thereof. "See Summary Plan Description"

Date claim signed _____ Signature _____ ←Particpant must sign here

See reverse side for Part B.....

IT IS UNLAWFUL TO FILE A FALSE OR FRAUDULENT CLAIM

PART B — ATTENDING PHYSICIAN'S STATEMENT

Dear Doctor: After Part A has been completed by your patient, please complete, sign and return to patient.

PATIENT'S NAME AND ADDRESS	DATE OF BIRTH

DATE PATIENT ABLE TO RETURN TO WORK	DATES OF TOTAL DISABILITY (Estimate If Not Known)
	FROM THROUGH

NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If Other Than Home or Office)

FREQUENCY OF VISITS	DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION

NATURE OF SICKNESS OR ILLNESS:

Remarks:

The Plan will not accept certification from a Chiropractor or Podiatrist for purposes of paying weekly disability benefits.

SIGNATURE OF PHYSICIAN	PHYSICIAN'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.
SIGNED DATE	

WEEKLY DISABILITY BENEFITS for Active Employees Only

If you are totally disabled due to an accident or sickness, and under the care of a legally qualified Physician, the Weekly Benefit will be paid to you beginning on the first day of an accident and the eighth day of an illness. Benefits are payable for up to 26 weeks during any disability as specified in the Schedule of Benefits.

NOTE: You must be eligible for benefits under the Plan and employed by a Participating Employer on the first day of the accident or sickness. Benefits for an accident or illness that occurred prior to the effective date of your coverage will not be payable.

During partial weeks of disability, you will be paid at the daily rate of one-seventh of the Weekly Benefit. Two or more periods of disability are considered as one unless, between periods of disability, you have returned to active full-time work for at least 14 consecutive working days, or unless the disabilities are due to causes entirely unrelated and begin after you have returned to full-time active work for at least one day. Provided, however, in no event will you receive more than twenty-six (26) weeks of weekly indemnity benefit payments during any single period of twelve (12) consecutive months. Benefits are not payable for any period of total disability during which you are not attended at least bi-monthly by a Physician. No benefits are payable for alcoholism or narcotics habits or for any injury or illness that occurs while not eligible under this Plan.

Weekly Disability Benefits – Active Employees Only
Weeks 1 through 4 = $250.00 per week
Weeks 5 through 26 (maximum 26 weeks) = $325.00 per week

LONG TERM PERMANENT DISABILITY

Your benefit program covers most cases of temporary disability. However, if disability is total and permanent and it looks as though you won't be able to work again, you may be eligible to receive benefits through one or more of the following sources:

IBEW Local 613 Defined Contribution Pension Plan, See your handbook for specific qualifications and the Social Security Administration

If you suffer a total and permanent disability, you may be eligible for income benefits under Social Security after six months of disability. The amount of your benefit will be the same full primary benefit as for retirement at Normal Retirement as defined by Social Security, based on your average earnings subject to Social Security under the law. For information on Social Security benefits, visit www.ssa.gov or contact your local office of the Social Security Administration.

Workers' Compensation

For disability due to occupational accidents, each state has Workers' Compensation laws which in general provide full medical expenses and substantial income payments to replace loss of earnings. The Plan will not pay medical expenses but will pay the weekly disability benefit.