LOSS OF TIME BENEFIT STATEMENT OF CLAIM

(PARTICIPANT TO COMPLETE THIS SIDE)

Mail to:

NECA/IBEW FAMILY MEDICAL CARE PLAN

5837 HIGHWAY 41 NORTH
RINGGOLD, GA 30736

Phone (706) 937-9600 Toll-Free (877) 937-9602 Fax (706) 937-9601

Participant's Name:_____

Social Security Number:_____

Address_____

Participant's Current or Last Employer:_____

Local Union No.:_____

Complete if Disability is due to an Accident:

1. Date of Accident:_____
2. Location of Accident:_____
3. Give Details of Accident:_____

_____

Complete if Disability is due to an Illness:

1. Date Symptoms First Appeared:_____
2. Nature of Illness:_____

Is this Disability Due to your Occupation? Yes_____ No_____

Is this Disability Covered by any Workers; Compensation or Occupational Disease Law? Yes_____ No_____

First Full Day Unable to Work_____

Date Resumed Work:_____
Or
Date Expected to Resume Work:_____

I certify that the above information is true and correct. I hereby authorize all doctors, hospitals, or other institutions rendering care and treatment to furnish the NECA/IBEW Family Medical Care Plan with full information regarding treatment rendered (including copies of records.)

_____ _____
Signature Date

ATTENDING PHYSICIAN MUST COMPLETE REVERSE SIDE

ATTENDING PHYSICIAN'S STATEMENT

Participant's Name:_____ SSN:_____

Diagnosis and Concurrent Conditions:

Primary Diagnosis:_____ ICD Code:_____

Secondary Diagnoses_____ ICD Code:_____

_____ ICD Code:_____

_____ ICD Code_____

Is Condition due to injury or illness arising out of patient's employment? Yes_____ No_____

Date Symptoms first appeared or accident occurred:_____

Date patient first consulted you for this condition:_____

Has patient every had the same or similar condition? Yes_____ No_____

If "Yes," when and describe:_____

Is patient still under your care for this condition? Yes_____ No_____

For purposes of this form, "Totally Disabled" means the complete inability of the patient to perform each and every duty of his occupation or employment.

Patient was continuously totally Disabled during the period from _____

through _____

If still disabled, the patient should be able to return to his regular employment on_____

_____ _____

Physician's Signature Date

_____

Physician's Name (Print) Degree Telephone Number

_____

Street Address City State Zip