RETURN FORM TO: **PLAN "A"**
I.B.E.W. LOCAL 25 HEALTH & BENEFIT FUND
372 VANDERBILT MOTOR PARKWAY
HAUPPAUGE, NEW YORK 11788

EMPLOYEE SUPPLEMENTAL PROOF OF LOSS OF TIME
DUE TO INJURY OR ILLNESS

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LAST FOUR OF SOCIAL SECURITY NUMBER

PARTICIPANT STATEMENT

Please complete each question in its entirety or benefits may be delayed or denied.

1. Name:_____Tel. No. _____
2. Address: _____
3. Last Employer is/was _____
4. Date disability commenced:_____ Date Last Worked: _____
5. Briefly describe this disability: _____
6. Did the injury/illness occur during employment? Yes☐ No☐
7. Did the injury occur due to a motorcycle accident? Yes☐ No☐
8. Did the injury occur due to an auto accident? Yes☐ No☐
9. If you answered "Yes" to question 8, has no-fault denied you benefits? Yes☐ No☐
10. Have you applied for STATE DISABILITY?_____WORKER'S COMPENSATION? _____

YOU <u>MUST</u> SUPPLY PROOF OF RECEIPT OF STATE DISABILITY OR WORKER'S COMPENSATION BENEFITS (*i.e.,* A COPY OF THE CHECK STUB) <u>WITH THIS FORM</u>. YOU ARE NOT ELIGIBLE FOR LOSS OF TIME BENEFITS IF YOU ARE NOT ELIGIBLE FOR STATE DISABILITY OR WORKER'S COMPENSATION BENEFITS. <u>IF PROOF OF RECEIPT IS NOT</u> <u>SUBMITTED WITH THIS FORM, YOUR APPLICATION WILL BE DENIED.</u>

11. If work has been resumed show date returned: _____

I AM/HAVE BEEN UNDER THE CARE OF MY PHYSICIAN AND AM/WAS UNABLE TO WORK DUE TO MY DISABILITY THROUGH THE DATE INDICATED.

I HEREBY ACKNOWLEDGE THAT (1) I AM RESPONSIBLE FOR CALLING THE FUND OFFICE AT 631-434-3344 <u>*IMMEDIATELY*</u> IF AND WHEN I RETURN TO WORK, (2) IF I HAVE RECEIVED PAYMENT FROM THE FUND FOR ANY HOUR(S) AFTER MY RETURN TO WORK, I AM NOT ENTITLED TO THAT PAYMENT AND MUST REIMBURSE THE FUND AT ONCE, AND (3) I AM NOT ENTITLED TO LOSS OF TIME BENEFITS FOR ANY PERIOD AFTER I BECOME ENTITLED TO SOCIAL SECURITY BENEFITS AND THAT IF MY SOCIAL SECURITY BENEFITS ARE RETROACTIVE, I MUST REIMBURSE THE FUND FOR ANY PAYEMENT(S) THAT MAY HAVE BEEN MADE TO ME FOR THE PERIOD AFTER I BECAME ENTITLED TO SOCIAL SECURITY BENEFITS.

DATE SIGNED_____ **SIGNATURE** _____

***<u>IMPORTANT!</u>* – REVERSE SIDE *<u>MUST</u>* BE COMPLETED BY YOUR PHYSICIAN**

ATTENDING PHYSICIAN'S STATEMENT

The named participant is under my care and is unable to work because of the following disability. A short description follows:

_____

_____

1. The disability occurred: ☐ ON ☐ OFF the job.
2. PARTICIPANT UNABLE TO WORK SINCE: _____
3. I ESTIMATE PARTICIPANT MAY RETURN TO WORK ON: _____

Physician's Name _____ Tel. No. _____

(Please Print or Type)

Date Signed:_____Physician's Signature _____