RETURN FORM TO:

PLAN "B" HOURS ONLY

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? _____

IMPORTANT: YOU MUST SUPPLY PROOF OF RECEIPT OF STATE DISABILITY OR WORKER'S COMPENSATION BENEFITS (*i.e.,* A COPY OF THE CHECK STUB, SHOWING THE DATES YOU WERE PAID) WITH THIS FORM. YOU ARE NOT ELIGIBLE FOR LOSS OF TIME HOUR BENEFITS IF YOU ARE NOT ELIGIBLE FOR STATE DISABILITY OR WORKER'S COMPENSATION BENEFITS. IF PROOF OF RECEIPT IS NOT SUBMITTED WITH THIS FORM, YOUR APPLICATION WILL BE DENIED.

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 I AM RESPONSIBLE FOR CALLING THE FUND OFFICE AT 631-434-3344 *IMMEDIATELY* IF AND WHEN I RETURN TO WORK

DATE SIGNED_____ SIGNATURE _____

***IMPORTANT!* – REVERSE SIDE *MUST* BE COMPLETED BY YOUR PHYSICIAN**

ATTENDING PHYSICIAN'S STATEMENT

The above 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 _____