RETURN THIS FORM TO:
4TH DISTRICT IBEW HEALTH FUND
9200 U. S. ROUTE 60
ONA, WV 25545

STATEMENT OF CLAIM
for
WEEKLY DISABILITY BENEFITS

IMPORTANT: COMPLETE CLAIM FORM FULLY AND ACCURATELY. FILING OF FALSE CLAIMS WILL RESULT IN LEGAL ACTION TO THE FULLEST EXTENT POSSIBLE AND THE DENIAL OF FUTURE BENEFITS.

PART 1 - EMPLOYEE COMPLETES IN ALL CASES.

Social Security No. ____________________

Local Union No. ____________________

1. Name of Employee ________________________________ Date of Birth____________________

2. Home Address____ Married ☐ Single ☐
   No. and Street City State Zip

3. IF ACCIDENT WAS INVOLVED, ANSWER THE FOLLOWING:
   a) When did the accident happen? Date: ____________________ 20_____.. at (hour)______________ am/pm
   b) Was the injured person at work when the accident happened? ☐Yes ☐No
   c) Was claim filed with Workman's Compensation? ☐Yes ☐No
   d) Give a brief description of the accident ________________________________
   e) Was there a third party involved? ☐Yes ☐No
   f) Was a claim filed with the third party's liability insurance for this claim? ☐Yes ☐No

3. On what date were you first totally disabled by the sickness or injury?____________________
4. On what date were you first treated by a physician? ____________________
5. On what date did you last work? ____________________
6. Are you still totally disabled by this sickness or injury? ____________________
7. Are you now wholly unable to physically engage in any work, occupation or business? ____________________
8. On what date were you last treated by a physician? ____________________
9. Have you returned to work?____________________ (a) If so, on what date? ____________________
   (b) If not, when do you expect to return to work?____________________
10. Have you applied for Social Security Disability benefits? __________Yes __________No
    a) Provide the effective date of the benefit. ____________________
    b) Provide the amount of the monthly benefit. ____________________
11. Have you applied for any Disability Pension Benefit? __________Yes __________No
    a) Provide the effective date of the benefit. ____________________
    b) Provide the amount of the monthly benefit. ____________________

12. I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and believe to be true, correct and complete. I hereby authorize any physician, or any hospital, to furnish and disclose all known facts concerning this disability to 4th District IBEW Health Fund. A copy or photocopy of this authorization shall be valid as the original.

Date this Claim Form Signed____________________ Employee's Signature ________________________________ Employee Sign Here

THE ATTENDING PHYSICIAN MUST COMPLETE THE NEXT PAGE SIDE OF THIS FORM.

PART 2- ATTENDING PHYSICIAN'S STATEMENT

1. Patient's name ______________________ Age __________ Accident Case? __________ (Yes or No)
2. Nature of sickness or injury (Describe complications, if any) ______________________

____
3. Did this sickness or injury arise out of patient's employment? Yes________ No__________

   If "Yes," explain ____

Date of Illness (First Symptom) or Injury (Accident) or Pregnancy (LMP)	Mo.	Day	Yr.	Date Patient First Consulted You for this Condition	Mo.	Day	Yr.	Has Patient ever had Same Similar Symptoms? ❑Yes ❑ No

A DATE OF SERVICE	B PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN		D DIAGNOSIS CODE	E CHARGES	F
		Procedure Code (Identify)	(Explain unusual services or circumstances)			

4. The patient has been continuously disabled (unable to work) from ______________, 20 _____ through ___________, 20____
   If still disabled, when should patient be able to return to work? ______________________________, 20____
5. To your knowledge, does patient have other health insurance or health plan coverage? If "Yes," identify.
   Yes ❑ ____ No❑

Date ______________________, 20____ Signed ______________________M.D.

Print Name ______________________

Physician's T.I.N. ______________________ (Must be furnished under authority of law.) Address ______________________

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304-525-0331