Revised January 24, 2019

NECA LOCAL NO. 145 IBEW WELFARE PLAN

SHORT-TERM DISABILITY FORM

An Active Participant will not be eligible to collect this benefit if collecting any another form of compensation with the exception of workers' compensation.

INSTRUCTIONS TO ACTIVE EMPLOYEE

1. This form is to be filed as soon as it appears that you will qualify for disability benefits.
2. Complete the Statement of Active Employee and the Authorization for Release of information below.
3. Have your physician complete the Attending Physician's Statement below.
4. **Include a completed ACH form. If Benefits Office does not receive this complete form, no payment will be issued.**
5. Return both forms (if applicable) to the Benefits Office. If this form is not completed properly no benefits will be paid until completed in its entirety.

STATEMENT OF ACTIVE EMPLOYEE

Name ____ Telephone Number ___________________________

Occupation ________________________ Date of Birth ________________ S.S. # _________________________

First Date of Total Disability _________________

Is disability due to accident _______ or sickness ________ (Mark one with Yes)

(If accident describe below, including date and place, if sickness when did symptoms first appear?)

____

Did disability result from employment? Yes_______ or No______

These statements are true and complete to the best of my knowledge

Signature of Active Employee ____ **Date** ________________

AUTHORIZATION FOR RELEASE OF INFORMATION

In order to process a claim for benefits. I authorize any physician, hospital or other medical provider to release to the Midwest Association of H&W Funds, NECA Local 145 IBEW Benefits Office or its representative, any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered valid for the duration of the claim, but not to exceed one year from date signed. I understand I have the right to receive a copy of this authorization.

Signature of Active Employee ____ **Date** _________________

Address of Active Employee

____

Street City State Zip Code

ATTENDING PHYSICAN'S STATEMENT

1. Description of diagnosis and concurrent conditions and applicable ICD codes: ___________________

   ____
2. Is condition due to injury or sickness arising out of patient's employment? Yes _____ No ______

   Pregnancy? Yes ____ No ______ if yes, approximate date pregnancy commended: _____________
3. Dates of Services (If previous for submittal to this carrier, you need only show dates since last report)

   ____
4. Date Symptoms first appeared or when injury/accident happened. _____________________________
5. Date patient first consulted you for this condition. ____
6. Has the Patient ever had same or similar condition? ____ Yes ____ No If "Yes", when and describe:____
7. Is the Patient still under your care for this condition? ____ Yes ____ No
8. Patient was or will be continuously disabled (unable to work **without** restrictions).

   From:__________________________ Through: __________________________

Signature of Physician____ **Date** ________________

Physician Name (Print)____

Address for Physician

____

Street City State Zip Code