RETURN FORM TO: **PLAN "B" 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

☐☐☐-☐☐-☐☐☐☐
SOCIAL SECURITY NUMBER

PARTICIPANT STATEMENT

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

1. My Name is: _____ Tel. No. _____
2. Home Address: _____
3. My Last Employer is/was _____
4. My Disability commenced _____ Date Last Worked: _____
5. Briefly describe this disability: _____
6. Did injury occur in the course of any employment? ☐ Yes ☐ No
7. Did injury occur due to an auto accident? ☐ Yes ☐ No
8. If you answered Yes to question 7, has no-fault denied you benefits? ☐ Yes ☐ No
9. Have you applied for *STATE DISABILITY? _____ or *WORKER'S COMPENSATION? _____

   *YOU ARE ELIGIBLE FOR LOSS OF TIME BENEFITS ONLY IF YOU ARE ELIGIBLE FOR STATE DISABILITY OR WORKER'S COMPENSATION BENEFITS.

10. If you answered Yes to question 8, give us the name and address of the insurance carrier providing the benefit.

    _____

    _____

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

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

IF AND WHEN I RETURN TO WORK, I KNOW I AM RESPONSIBLE FOR CALLING THE FUND OFFICE AT 631-434-3344 *IMMEDIATELY*. IF ANY PAYMENT(S) HAS BEEN MADE TO ME BY THE FUND AFTER MY RETURN TO WORK, I KNOW I MUST REIMBURSE THE FUND AT ONCE.

DATE SIGNED_____ SIGNATURE _____

PLEASE NOTE – 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 _____

IMPORTANT: IF AT ANY TIME YOU BECOME ENTITLED TO SOCIAL SECURITY BENEFITS YOU ARE NO LONGER ENTITLED TO LOSS OF TIME BENEFITS. IF SOCIAL SECURITYY BENEFITS ARE RETROACTIVE, YOU ARE OBLIGATED TO REIMBURSE TO THE FUND ANY BENEFITS YOU RECEIVED DURING THE PERIOD OF TIME THAT YOU BECAME ENTITLED TO SOCIAL SECURITY BENEFITS.