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

PLAN "A" ONLY

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 a motorcycle accident? ☐ Yes ☐ No
8. Did 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 MUST SUPPLY PROOF OF RECEIPT OF STATE DISABILITY OR WORKER'S COMPENSATION BENEFITS (*i.e.*, A COPY OF THE CHECK STUB) WITH THIS FORM. YOU ARE NOT ELIGIBLE FOR LOSS OF TIME 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.

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 *IMMEDIATELY* 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** _____

***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 _____