NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN

SPECIAL 14-DAY WEEKLY INCOME BENEFIT FORM (COVID-19 QUARANTINE)

Instructions: Complete "PLAN MEMBER" Section Only.

SEND TO:

Email: weeklyincome@neibenefits.org
(610) 557-4556 (fax)

National Elevator Industry Health Benefit Plan
PO Box 476

Newtown Square, PA 19073-0476

	TO BE COMPL	ETED BY MEMBER	
Name	Last Four of Social Security No		
Street		Birth Date	Local Union No.
City	State	Zip Code	Phone
Employer Name		Las	it day worked
Employer Contact	Employer Phone Number		
Check the appropriate box:			
 My Employer directed me to Self-Quarantin My Employer did not direct me to Self-Quarantin have symptoms of COVID-19 (subjective or 	rantine, but I believe	e I should Self-Quarantine	because I have been exposed to COVID-19 or
Direct Deposit Election Yes No CH If direct deposit is elected, A BLANK PERSONA			MPANY THIS FORM.
Account Number		Banking Routing Numb	per
Bank Name		Street	
City	State	Zip Code	Phone
I request voluntary Federal Withholding Yes	No If "Yes", inc	dicate amount to be withhe	eld from weekly benefit. \$
I am the payee under the above Social Security Nu Administrator, all payments be directly deposited in account and to refund any overpayments to the Na I agree to reimburse the Health Benefit Plan to the Plan. ANY PERSON WHO KNOWINGLY FILES A STAT INFORMATION, WITH INTENT TO INJURE, DEFI AND SUBJECT TO LOSS OF HEALTH BENEFIT I certify that the statements hereon are complete a considered as effective and valid as the original.	n my account at the hitional Elevator Indu- extent of any overp EMENT OF CLAIM RAUD OR DECEIVI PLAN COVERAGE	Bank designated above. Istry Health Benefit Plan. Dayment which is in excess CONTAINING ANY FALS E, MAY BE GUILTY OF A	I authorize the Bank designated to debit my sof the amounts payable under provisions of the SE, INCOMPLETE, OR MISLEADING CRIMINAL ACT PUNISHABLE UNDER LAW
Signature of Plan Member			Date
IMPORTANT: By submitting this form, you are Active Members who <u>Self-Quarantine on accou</u> lnjury you must submit the applicable Weekly In these forms are available online at <u>www.neiber</u>	nt of COVID-19. If ncome Claim Forn	you wish to apply for W n which must also be fille	eekly Income Benefits on account of Illness of
TO B	E COMPLETED I	BY THE BENEFITS OF	FICE
Employer NameAddress			
Employee Self-Quarantine Confirmed YES If "Yes" Date If "No" explanation:	NO		
Reviewed by			