NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN
REQUEST FOR EXTENDED BENEFITS COVERAGE FOR PARTICIPANTS ON WORKER'S COMPENSATION

RETURN FORM TO:

National Elevator Industry Benefit Plans
19 Campus Blvd., Suite 200
Newtown Square PA 19073-3228
1-800-523-4702

Employee Name _____ ID #:_____

Employee Address _____
(No., Street, City, State, Zip Code)

ATTENDING PHYSICIAN'S STATEMENT*

WHAT IS THE PATIENT'S CURRENT STANDARD NOMENCLATURE DIAGNOSIS (INCLUDING ANY COMPLICATIONS)?	
ICD-9-CM (Primary)	DESCRIPTION:
ICD-9-CM (Secondary)	DESCRIPTION:

IS OR WAS THE ILLNESS/INJURY WORK RELATED? ☐YES ☐NO

Give dates of treatments.

Office _____

Hospital _____

Date of Next Scheduled Appointment _____

IS OR HAS THE PATIENT BEEN DISABLED FROM PERFORMING HIS/HER OCCUPATION? ☐YES ☐NO

IF YES, GIVE THE DISABILITY PERIOD: **FROM: _____ TO:**

STATE SPECIFICALLY HOW AND WHY THIS CONDITION PHYSICALLY AND/OR MENTALLY PREVENTS THE PATIENT FROM PERFORMING HIS/HER **NORMAL OCCUPATION**:

Is patient still under your care for this condition? _____If discharged, give date._____

Progress: Recovered ☐ Improved ☐ Unimproved ☐ Retrogressed ☐

IF TOTAL DISABILITY IS CONTINUING, WHEN WILL THE PATIENT BE ABLE TO RETURN TO WORK AT HIS/HER REGULAR OCCUPATION?
PLEASE SUPPLY AN APPROXIMATE DATE. _____/_____/_____

DOCTOR'S NAME	DEGREE	BOARD CERTIFIED SPECIALTY
ADDRESS *(No., Street, City, State, Zip Code)*		
TELEPHONE NO. ( )		TAXPAYER I.D. NUMBER

I hereby certify that the information provided above is true and accurate to the best of my knowledge.

Physician's Signature _____Date _____

DEFINITION OF "DISABILITY" EFFECTIVE FEBRUARY 1, 1989

For purposes of eligibility for continuing benefits due to disability, "disability" or "disabled" shall mean, during the first two years, complete inability to perform their regular duties as an Elevator Constructor Mechanic or Helper. ELIGIBILITY FOR BENEFITS IS SUBJECT TO REVIEW BY N.E.I. HEALTH BENEFIT PLAN. *THIS FORM IS TO BE FURNISHED WITHOUT COST TO THE PLAN*