INTERNATIONAL UNION OF ELEVATOR CONSTRUCTORS
LOCAL NO. 18 • AFL-CIO

Dear Member:

Please find enclosed disability paper work. Please have completed and returned to address on forms.

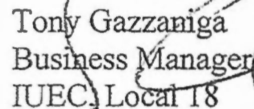
I.U-E.C. Local #18 will not in any way be responsible for any fees charged to have these forms completed.

You as the member will be responsible for any up-dates due to your disability. (Extensions, release, laid off, long-term status, etc.)

The form information that we have on file is what we will go by. If no update is received by the time of expiration, we will re-code you as back to work and bill you accordingly.

Please keep us current with your status. If you have any questions, please give us a call.

Thank you,



Tony Gazzaniga
Business Manager
IUEC, Local 18

(800) 428-5226
2011 E. Financial Way, Glendora, CA 91741 • Fax (626) 577-1055
3301 Spring Mountain Rd., Suite 1, Las Vegas, Nevada 89102 • Fax (702) 251-4832
4636 Mission Gorge Place, Suite 204, San Diego California 92120 • Fax (619) 280-2826
www.IUECLOCAL18.org

NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN

REQUEST FOR EXTENDED BENEFITS COVERAGE

RETURN FORM TO:
IUEC LOCAL #18
2011 E. Financial Way
Glendora, CA 91741

Employee Name ___________________________________ Soc. Sec. No.________________________

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:

Give dates of treatments.

Since_________________________________

Office:____

Home:____

Hospital:____

Date of Next Scheduled Appointment ____

Is patient still under your care for this condition? ___________ If discharged, give date.___________________________

IS OR HAS THE PATIENT BEEN TOTALLY 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**:

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*

NATIONAL ELEVATOR INDUSTRY
HEALTH BENEFIT PLAN

WEEKLY INCOME CLAIM FORM

Instructions: BOTH SIDES of this form must be completed.

SEND TO:
NATIONAL ELEVATOR INDUSTRY
HEALTH BENEFIT PLAN
PO Box 476
NEWTOWN SQUARE, PA 19073-0476
PHONE 1-800-252-4611
FAX (610) 557-4556

This form is not to be used for Members working in NY, NJ, HI

TO BE COMPLETED BY PLAN MEMBER

Name ____ Social Security No. _____________________________

Street ____ Birth Date _____________ Local Union No. __________

City _________________________________ State _______ Zip Code _____________ Phone ( ) __________________________

Describe illness or injury ____ Last day worked ____________________

Was illness or injury related to an accident? ☐ Yes ☐ No If "Yes", date of the accident ____

How did the accident happen? ____

As a result of the accident, have you filed, or will you file a claim with any another insurance carrier? ☐ Yes ☐ No

If "Yes" to the above, insurance carrier Name_______________________________ Claim Number_____________ Phone ( )_____________

Was illness or injury in any way work-related? ☐ Yes ☐ No If "Yes", please explain ____

If work related, did you notify your employer? ☐ Yes ☐ No Have you filed a claim with your workers compensation carrier? ☐ Yes ☐ No

If "Yes" to the above, insurance carrier Name_______________________________ Claim Number_____________ Phone ( )_____________

Direct Deposit Election ☐ **Yes** ☐ **No** **CHECKING ACCOUNT DEPOSITS ONLY**
If direct deposit is elected, ***A BLANK PERSONAL CHECK (MARKED VOID) MUST ACCOMPANY THIS FORM.***

Account Number __________________________________ **Bank Routing Number**____

Bank Name __________________________________ **Street** ____

City __________________________________ **State** ___________ **Zip Code** __________________ **Phone (** **)**___________________

I request voluntary Federal Withholding ☐ Yes ☐ No If "Yes", indicate amount to be withheld from weekly benefits. $____________________

I am the payee under the above Social Security number and I hereby request that until further written notice from me is filed with the Claims Administrator, all payments be directly deposited in my account at the Bank designated above. I authorize the Bank designated to debit my account and to refund any overpayments to the National Elevator Industry Health Benefit Plan.

I agree to reimburse the Health Benefit Plan to the extent of any overpayment which is in excess of the amounts payable under provisions of the Plan.

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION, WITH INTENT TO INJURE, DEFRAUD OR DECEIVE, MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND SUBJECT TO LOSS OF HEALTH PLAN COVERAGE.

I certify that the statements hereon are complete and accurate to the best of my knowledge. I further authorize the release of any medical information necessary to process this claim. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Plan Member ____ **Date** _______________________________

MEDICAL CERTIFICATION (TO BE COMPLETED BY YOUR ATTENDING PHYSICIAN)

Patient's Name ____ Birth Date ______________________
Month / Day / Year

Date patient was first treated by you specific to this disability ______________________________
Month / Day / Year

Date patient was last treated by you specific to this disability ______________________________
Month / Day / Year

Diagnosis (nature and cause of the disability which prevents patient from working) _________________________ ICD Code__________

In your opinion, was this disability in any way related to his/her employment? ☐ Yes ☐ No

Patient is now / was totally disabled From ________________________ Thru ________________________
Month / Day / Year Month / Day / Year

Approximate date patient will be able to return to work (Do Not Use "unknown" or "undetermined") ______________________ ☐ Never
Month / Day / Year

Has the patient been hospitalized? ☐ Yes ☐ No From ______________________ Thru ______________________
Month / Day / Year Month / Day / Year

Patient had / will have surgery specific to this disability? ☐ Yes ☐ No

Type of Surgery ________________________ CPT Code ____________ Date of Surgery ______________________
Month / Day / Year

ATTENDING PHYSICIAN (This statement to be completed at no cost to National Elevator Industry Health Benefit Plan)

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

Name ____ Degree _______ Specialty ______________________
(Print Physician's Name)

Address ____ State License No. ______________________
Street

____ Telephone ( )______________________
City State Zip Code

Physician's Signature ____ Date ______________________________
Month / Day / Year

TO BE COMPLETED BY YOUR EMPLOYER

Member's Name ____ Social Security No. ____________________

Last Day Worked ______________________________ Date Returned to Work (if applicable) ______________________

Exact reason for separation from work on the date listed above ____

Was illness or injury in any way work-related? ☐ Yes ☐ No If "Yes", please explain ______________________________

Employer Name ____ EIN ______________________________
Federal Employer Identification Number

Address ____ Telephone ( )________________Ext.__________
Street

____
City State Zip Code

Completed by ____
Please Print Name & Title

Signature ____ Date ______________________________
I hereby certify that the above information is true and complete to the best of my knowledge Month / Day / Year