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