410 Chickamauga Ave
Suite 301
Rossville, GA 30741

Phone (706) 841-7000
Toll Free (877) 937-9602
Fax (706) 841-7020
www.nifmcp.com

LOSS OF TIME BENEFIT STATEMENT OF CLAIM

(PARTICIPANT TO COMPLETE THIS SIDE)

Mail to:
NECA/IBEW FAMILY MEDICAL CARE PLAN
410 CHICKAMAUGA AVE, SUITE 301
ROSSVILLE, GA 30741

Participant's Name: _____

Social Security Number: _____ Date of Birth: _____

Address: _____

Email Address: _____

Cell Phone Number: _____

Participant's Current or Last Employer: _____

Local Union No.: _____

Complete if Disability is due to an Illness:

1. Date Symptoms First Appeared: _____
2. Nature of Illness: _____

Complete if Disability is due to an Accident:

1. Date of Accident: _____
2. Location of Accident: _____
3. Give Details of Accident: _____

Is this Disability Due to your Occupation? Yes_____ No_____

Is this Disability Covered by any Workers; Compensation or Occupational Disease Law? Yes_____No _____

First Full Day Unable to Work _____

Date Resumed Work: _____
Or
Date Expected to Resume Work: _____

Have you been approved for a Social Security Disability Benefit? Yes _____ No _____ Pending _____

Date of Social Security Disability Award: ☐☐ / ☐☐ / ☐☐
Month Day Year

Note: If you have been approved for Social Security Disability, please submit all pages of your Social Security Disability Award.

I certify that the above information is true and correct. I hereby authorize all doctors, hospitals, or other institutions rendering care and treatment to furnish the NECA/IBEW Family Medical Care Plan with full information regarding treatment rendered (including copies of records.)

_____ _____
Signature Date

ATTENDING PHYSICIAN MUST COMPLETE REVERSE SIDE

ATTENDING PHYSICIAN'S STATEMENT

Participant's Name: _____

SSN: _____ Date of Birth: _____

Diagnosis and Concurrent Conditions:

Primary Diagnosis: _____ ICD Code: _____

Secondary Diagnoses: _____ ICD Code: _____

_____ ICD Code: _____

_____ ICD Code: _____

Is Condition due to injury or illness arising out of patient's employment? Yes____No____

Date Symptoms first appeared or accident occurred: _____

Date patient first consulted you for this condition: _____

Has patient ever had the same or similar condition? Yes____ No____

If "Yes," when and describe: _____

Is patient still under your care for this condition? Yes____ No____

Is patient receiving inpatient or outpatient care due to their diagnosis? Inpatient____ Outpatient____

For purposes of this form, "Totally Disabled" means the complete inability of the patient to perform each and every duty of his occupation or employment.

Patient has been Totally Disabled starting from _____

and should be able to return to his regular employment on _____.

_____ _____

Physician's Signature Date

_____

Physician's Name (Print) Degree Telephone Number

_____

Street Address City State Zip