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
Or submit via email to:
disabilitysupport@nifmcp.com

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 Worker's 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 (this does not refer to State Disability Insurance)?

Yes_______ No _____ Pending ______

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

I certify that the above information is true and correct and acknowledge failure to provide accurate information may result in loss of benefits retroactively. I authorize all doctors, hospitals, or other institutions rendering care and treatment to furnish the NECA/IBEW Family Medical Care Plan with any and all information regarding treatment rendered (including copies of records related to such treatment.)

____ ______________________
Signature Date

ATTENDING PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN'S ASSISTANT MUST COMPLETE REVERSE

STATEMENT BY ATTENDING PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN'S ASSISTANT

Participant's Name: ____

SSN: ________________________________ Date of Birth: ____________________________

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, "Disabled" means the patient is unable to work in the trade as a result of an accidental injury or sickness and is completely unable to perform each and every duty of his occupation or employment.

Patient has been **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