

# LOSS OF TIME BENEFIT STATEMENT OF CLAIM

(PARTICIPANT TO COMPLETE THIS SIDE)

MAIL TO:

**NECA/IBEW FAMILY MEDICAL CARE PLAN**

**35 Harley Lane**

**Ringgold, GA 30736**

**Phone: (706) 937-9600 • Toll-Free: (877) 937-9602 • Fax: (706) 937-9601**

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Participant's Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Participant's Current or Last Employer: \_\_\_\_\_

Local Union No.: \_\_\_\_\_

Complete if Disability is due to an Accident:

1. Date of Accident: \_\_\_\_\_

2. Location of Accident: \_\_\_\_\_

3. Give Details of Accident: \_\_\_\_\_

Complete if Disability is due to an Illness:

1. Date Symptoms First Appeared: \_\_\_\_\_

2. Nature of Illness: \_\_\_\_\_

Is this Disability Due to your Occupation?  Yes  No

Is this Disability covered by or is a claim being made to any Workers' Compensation or Occupational Disease Law?  Yes  No

First Full Day Unable to Work: \_\_\_\_\_

Date Resumed Work: \_\_\_\_\_

Or

Date Expected to Resume Work: \_\_\_\_\_  Undetermined

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: \_\_\_\_\_

Diagnosis and Concurrent Conditions: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_ 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: \_\_\_\_\_

Since last report, this patient was hospitalized from: \_\_\_\_\_

Name of hospital: \_\_\_\_\_

Location: \_\_\_\_\_

Are you still treating patient?  Yes  No

Date of last treatment: \_\_\_\_\_ Date of next appointment: \_\_\_\_\_

**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 was continuously Totally Disabled (unable to return to regular work) from: \_\_\_\_\_

Patient recovered, or will recover, sufficiently to return to his regular job on: \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature Date

\_\_\_\_\_  
Physician's Name & Degree (Print) SS or Tax ID No. Telephone Number

\_\_\_\_\_  
Street Address City State Zip