I.B.E.W. 292 Health Care Plan

Loss of Time Application

It is the responsibility of the member to see that all sections of this form are complete, questions answered, all necessary medical records and notes from all treating health care providers are provided, and the form returned to the plan office at **6900 Wedgwood Road N., Suite 425, Maple Grove, MN 55311, Ph. (763) 493-8830 or (800) 368-9045 Fax (763) 416-6196, or via email at: claiminfo@ibew292benefits.com**

For applications related to Mental Health and Chemical Dependency, TEAM serves as case manager and will make final decisions regarding these benefits.

Please Type or Print

Employee's Statement

1. Name: _____ ID Number**:** _____

2. Home Address: _____ Phone Number: _____

3. Effective Date of Coverage: _____ Date of Birth: _____

4. I became unable to perform all of the essential functions of my job on _____

5. I last worked preceding disability on _____

6. I returned to work on/expect to return to work on _____

7. Is disability due to accident Yes☐ No☐ If yes:

   a. Where did the accident occur? _____

   b. When did the accident occur? _____

   c. How did the accident occur? _____

   d. If the accident was a motor vehicle accident, please provide the car insurance information for all those involved in the accident. _____

   _____

8. Was the injury incurred while working for profit or wages: Yes☐ No☐ If Yes, explain _____

   _____

9. Have you presented, or do you intend to present, a Workers' Compensation Claim: Yes_____ No_____

10. Are you receiving any other wage or wage replacement (*i.e.* unemployment, auto insurance, homeowners insurance, social security/disability benefits)? _____ If yes, in what amount? _____

11. I hereby understand that it is my obligation to provide all necessary medical records and notes, from all treating health care providers, to the I.B.E.W. 292 Health Care Plan to support this application. In conjunction with that obligation, I authorize release of medical information to I.B.E.W. 292 Health Care Plan in order to receive Loss of Time Benefits. I certify that the above statement is true. I also authorize release of workability to the International Brotherhood of Electrical Workers Local Union No. 292 Hiring Hall.

Date: _____ Employee's Signature_____

Employer's Statement

1. Employee Name: _____ Job Title: _____
2. Employer Name and Address: _____
3. Base Weekly Wage: _____
4. Has employment terminated? _____ If yes, Date of Termination: _____
5. Date employee last worked preceding disability: _____
6. Date disability began: _____
7. Has disability ceased? _____ If yes, date employee returned to work: _____

   If no, date expected to return to work? _____

   Is Employee entitled to compensation for loss of time due to illness or injury through his employer, i.e., sick leave or salary continuation coverage? Yes _____ No _____. If yes, explain below.

   _____
8. Is there any possibility of a claim under Workers' Compensation Act or similar law? Yes_____ No _____. If yes, explain below.

   _____

Employer's Signature: _____

Title: _____

Phone No.: _____

Date: _____