IBEW 292 Benefits Office

6700 W. Broadway Ave, Ste B
Brooklyn Park, MN 55428

(763) 493-8830 | (800) 368-9045 | ibew292benefits.org | claiminfo@ibew292benefits.com

It is the responsibility of the member to see that all sections of this form are complete, questions answered and the form returned to the plan office at **6700 W. Broadway Ave., Suite B, Brooklyn Park, MN 55428 Ph. (763) 493-8830 or (800) 368-9045 Fax (763) 416-6196 Email:** claiminfo@ibew292benefits.com

Employee's Statement

1. Name _____ Social Security Number _____
2. Home Address _____ Phone Number _____
3. Effective Date of Coverage _____ Date of Birth _____
4. I became totally disabled and unable to perform my job in any capacity on _____
5. I last worked preceding disability on_____
6. I returned to work on _____ I expect to return to work on _____
7. Is disability due to accident/ injury Yes_____ No _____ If yes, explain below.

- How _____
- When_____
- Where_____
- If accident is related to motor vehicle accident, please provide car insurance information for all those involved in the accident _____

Describe the illness, injury, or accident that caused your disability.

If your disability is due to an accident or injury, please include: (a) the activity you were doing when it happened (for example, working, driving, home project, recreation); (b) the location (for example, job site, home, roadway, business premises), and whether it was a motor vehicle accident; (c) whether any other person, company, or property owner may have caused or contributed to the accident, and if so, their name and any insurance information you have; (d) whether a police, accident, or incident report was made, and if so, the agency or employer that made it; (e) the names of any witnesses; and (f) the specific job duties you are currently unable to perform because of this condition.

_____

_____

_____

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Employee's Statement

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

If yes, explain_____

_____

Have you presented, or do you intend to present, a Workers' Compensation Claim: Yes _____ No _____

I hereby authorize release of medical information to IBEW Local #292 Health Care Plan to receive Loss of Time Benefits and do certify that the above statement is true. I also authorize release of workability to the IBEW #292 Hiring Hall.

Date: _____ Employee's Signature _____

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Employer's Statement

1. Employee _____ Job Title _____

   Basic Weekly Wage _____

2. Employer _____

   Address _____

3. Has employment terminated? Yes _____ No _____ If Yes, date: _____

4. Date employee last worked preceding disability. _____

5. Date disability began. _____

6. Has disability ceased: Yes_____ No _____ If Yes, date employee returned to work? _____

   If not returned, date expected to return to work. _____

7. Is Employee entitled to compensation for loss of time due to illness or injury through his employer, i.e., sick leave or a 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_____

   Date signed _____ Employer's Signature _____

   Phone No. _____ Position _____