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 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 (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 PRACTTIIONER, OR PHYSICIAN'S ASSISTANT MUST COMPLETE REVERSE SIDE

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