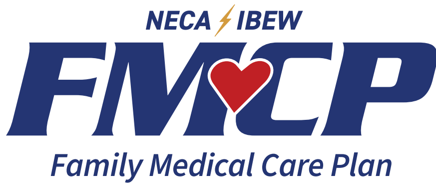

Phone (706) 841-7000 • Toll Free (877) 937-9602
Fax: (706) 841-7020 • www.nifmcp.com

LOSS OF TIME BENEFIT STATEMENT OF CLAIM

Return the completed form by email to disabilitysupport@nifmcp.com or by mail to:
NECA/IBEW Family Medical Care Plan
410 Chickamauga Avenue, Suite 301
Rossville, GA 30711

PARTICIPANT MUST COMPLETE PAGE 1.
ATTENDING PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT MUST COMPLETE PAGE 2.

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: ______________________

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 acknowledge that failure to recertify or provide proper documentation may result in overpayment which may be recouped by the Plan, and the Plan has the right to withhold payments on behalf of me and/or my dependents to other providers of benefits through the Plan until the disability overpayment is recouped in full. 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 ______________________

STATEMENT BY ATTENDING PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT

Participant's Name: ______________________________

Social Security Number: ____________________ 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 their occupation or employment.

Patient has been **disabled** starting from ____________________

and should be able to return to their regular employment on ____________________

______________________________ ____________
Physician's Signature Date

____________________ ____________ ____________
Physician's Name (Print) Degree Telephone Number

____________________ ____________ ______ ______
Street Address City State Zip