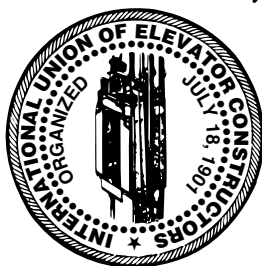


# International Union of Elevator Constructors

AFFILIATED WITH THE  
AFL-CIO  
PHONE (415) 285-2900  
FAX (415) 285-2020



LOCAL UNION NO.8  
690 POTRERO AVENUE  
SAN FRANCISCO, CA 94110-2117



Dear Member:

We are sorry to hear about your recent disability. This letter will explain your benefits, and any forms we have included that should be filled out and returned to the proper entities.

On-the-Job Accident: You may be eligible for benefits from your company's Worker's Compensation insurance carrier. Your company should fill out this paperwork. While receiving Worker's Comp, Local 8 has a disability benefit you may be eligible for, and an application will be enclosed, to be returned to the Union Hall. In addition, there is a form for the NEI Benefit Plans office that must be filled out by your physician and returned to the NEI Benefit Plans office. **Failure to submit this form to the plan office will result in a loss of benefits.**

Off-the-Job Disability: You may be eligible for State Disability and National Elevator Industry Weekly Income. You should obtain the State Disability Form from your doctor or the State Employment Development Department. The Weekly Income Claim form will be enclosed, and has sections that must be filled out by your physician, as well as your employer, and returned to the NEI Benefit Plans office. **Failure to submit this form to the plan office will result in a loss of benefits.**

Dues: On short-term disabilities, your dues are still due and payable. On long-term disabilities (3 months or longer), your dues may be paid by the Local at the discretion of the Executive Board (Sick Pay By Union). If you are out a minimum of 8 weeks, but less than 13 necessary for SPBU, you may also be eligible to receive Dues Relief, which gives a partial credit towards dues. To be eligible for either SPBU or Dues Relief your dues must be current for the quarter in which you last worked. Should you feel you qualify for SPBU, complete the form, have it signed by your physician, and return it to the Union Hall. *(Please note – any assessments on your dues statement will still be due and payable while disabled.)*

Insurance: Your benefits continue while you are disabled. However, you must notify the NEI Benefit Plans office of your disability immediately by calling (800) 523-4702, and submit the appropriate forms as noted above. **Failure to submit the proper forms to the plan office will result in a loss of benefits.** Your benefits continue without payment up to a maximum of six (6) months. After the six (6) months, you may purchase Extended Benefits.

We hope you return to work soon.

Sincerely,

Matt Russo  
Business Manager

MAR/mrs





NATIONAL ELEVATOR INDUSTRY  
HEALTH BENEFIT PLAN

WEEKLY INCOME CLAIM FORM

SEND TO:

NATIONAL ELEVATOR INDUSTRY  
HEALTH BENEFIT PLAN  
PO Box 476  
NEWTOWN SQUARE, PA 19073-0476  
PHONE 1-800-252-4611  
FAX (610) 557-4556

**Instructions: BOTH SIDES of this form must be completed.**

*This form is not to be used for Members working in NY, NJ, HI*

**TO BE COMPLETED BY PLAN MEMBER**

Name \_\_\_\_\_ Social Security No. \_\_\_\_\_

Street \_\_\_\_\_ Birth Date \_\_\_\_\_ Local Union No. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Describe illness or injury \_\_\_\_\_ Last day worked \_\_\_\_\_

Was illness or injury related to an accident?  Yes  No If "Yes", date of the accident \_\_\_\_\_

How did the accident happen? \_\_\_\_\_

As a result of the accident, have you filed, or will you file a claim with any another insurance carrier?  Yes  No

If "Yes" to the above, insurance carrier Name \_\_\_\_\_ Claim Number \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Was illness or injury in any way work-related?  Yes  No If "Yes", please explain \_\_\_\_\_

If work related, did you notify your employer?  Yes  No Have you filed a claim with your workers compensation carrier?  Yes  No

If "Yes" to the above, insurance carrier Name \_\_\_\_\_ Claim Number \_\_\_\_\_ Phone ( ) \_\_\_\_\_

**Direct Deposit Election**  Yes  No **CHECKING ACCOUNT DEPOSITS ONLY**

**If direct deposit is elected, A BLANK PERSONAL CHECK (MARKED VOID) MUST ACCOMPANY THIS FORM.**

Account Number \_\_\_\_\_ Bank Routing Number \_\_\_\_\_

Bank Name \_\_\_\_\_ Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone ( ) \_\_\_\_\_

I request voluntary Federal Withholding  Yes  No If "Yes", indicate amount to be withheld from weekly benefits. \$ \_\_\_\_\_

I am the payee under the above Social Security number and I hereby request that until further written notice from me is filed with the Claims Administrator, all payments be directly deposited in my account at the Bank designated above. I authorize the Bank designated to debit my account and to refund any overpayments to the National Elevator Industry Health Benefit Plan.

I agree to reimburse the Health Benefit Plan to the extent of any overpayment which is in excess of the amounts payable under provisions of the Plan.

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION, WITH INTENT TO INJURE, DEFRAUD OR DECEIVE, MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND SUBJECT TO LOSS OF HEALTH PLAN COVERAGE.

I certify that the statements hereon are complete and accurate to the best of my knowledge. I further authorize the release of any medical information necessary to process this claim. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Plan Member \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL CERTIFICATION (TO BE COMPLETED BY YOUR ATTENDING PHYSICIAN)**

Patient's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Month / Day / Year

Date patient was first treated by you specific to this disability \_\_\_\_\_  
Month / Day / Year

Date patient was last treated by you specific to this disability \_\_\_\_\_  
Month / Day / Year

Diagnosis (nature and cause of the disability which prevents patient from working) \_\_\_\_\_ ICD Code \_\_\_\_\_

In your opinion, was this disability in any way related to his/her employment?  Yes  No

Patient is now / was totally disabled From \_\_\_\_\_ Thru \_\_\_\_\_  
Month / Day / Year Month / Day / Year

Approximate date patient will be able to return to work (Do Not Use "unknown" or "undetermined") \_\_\_\_\_  Never  
Month / Day / Year

Has the patient been hospitalized?  Yes  No From \_\_\_\_\_ Thru \_\_\_\_\_  
Month / Day / Year Month / Day / Year

Patient had / will have surgery specific to this disability?  Yes  No

Type of Surgery \_\_\_\_\_ CPT Code \_\_\_\_\_ Date of Surgery \_\_\_\_\_  
Month / Day / Year

**ATTENDING PHYSICIAN (This statement to be completed at no cost to National Elevator Industry Health Benefit Plan)**

*I hereby certify that the above information is true and complete to the best of my knowledge.*

Name \_\_\_\_\_ Degree \_\_\_\_\_ Specialty \_\_\_\_\_  
(Print Physician's Name)

Address \_\_\_\_\_ State License No. \_\_\_\_\_  
Street  
City State Zip Code Telephone ( ) \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_  
Month / Day / Year

**TO BE COMPLETED BY YOUR EMPLOYER**

Member's Name \_\_\_\_\_ Social Security No. \_\_\_\_\_

Last Day Worked \_\_\_\_\_ Date Returned to Work (if applicable) \_\_\_\_\_

Exact reason for separation from work on the date listed above \_\_\_\_\_

Was illness or injury in any way work-related?  Yes  No If "Yes", please explain \_\_\_\_\_

Employer Name \_\_\_\_\_ EIN \_\_\_\_\_  
Federal Employer Identification Number

Address \_\_\_\_\_ Telephone ( ) \_\_\_\_\_ Ext. \_\_\_\_\_  
Street  
City State Zip Code

Completed by \_\_\_\_\_  
Please Print Name & Title

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Month / Day / Year

*I hereby certify that the above information is true and complete to the best of my knowledge.*

# Sick Pay By Union (S.P.B.U.)

Date \_\_\_\_\_

To: Executive Board of IUEC Local 8

I hereby request that my dues be paid by the Union as provided for in Article XI, Section 5 of Local 8's Constitution and By-Laws.

I understand I must be on disability for a minimum of 13 weeks in order to qualify, and **failure to submit a form in a timely manner may result in suspension of membership for failure to pay dues.**

Name \_\_\_\_\_ S.S.# \_\_\_\_\_  
(print)

Last day worked \_\_\_\_\_ Employer \_\_\_\_\_

Current address \_\_\_\_\_ Phone # \_\_\_\_\_

\_\_\_\_\_ Email \_\_\_\_\_

\_\_\_\_\_ Signature \_\_\_\_\_

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Doctor's Statement

Type of Disability \_\_\_\_\_

Date of Injury or Illness \_\_\_\_\_

Date Return to Work \_\_\_\_\_

Doctor's Signature \_\_\_\_\_

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**OFFICE USE ONLY. DO NOT FILL IN.**

Last quarter dues paid \_\_\_\_\_ Quarter granted \_\_\_\_\_

Executive Board date \_\_\_\_\_

