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

INTERNATIONAL UNION OF ELEVATOR CONSTRUCTORS LOCAL NO. 8

APPLICATION FOR DISABILITY BENEFIT FOR ON THE JOB INJURY

Name_____
(print)

Employer_____

Type of injury_____

Date of injury_____

Place where it happened_____

First full day lost to injury_____

Date released to return to work by doctor _____

Copies of the pay stubs from Workers' Compensation must be included with this request.

Payments are made monthly. Payments are recommended by the Trustees on the Executive Board meeting night and are submitted for approval by the membership at the General Meeting. **Copies of the pay stubs from Workers' Compensation must be sent in every month before the Executive Board meeting night to be processed.**

The maximum benefit for each separate injury is 130 days

Benefit checks will be mailed following the General Meeting.

Incomplete forms will not be processed. If you need assistance, please call the Union Office. If you are unable to sign this form, have someone sign it for you before mailing.

Signature of Member _____

NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN
REQUEST FOR EXTENDED BENEFITS COVERAGE FOR PARTICIPANTS ON WORKER'S COMPENSATION

RETURN FORM TO:

National Elevator Industry Benefit Plans
19 Campus Blvd., Suite 200
Newtown Square PA 19073-3228
1-800-523-4702

Employee Name _____ ID #:_____

Employee Address _____
(No., Street, City, State, Zip Code)

ATTENDING PHYSICIAN'S STATEMENT*

WHAT IS THE PATIENT'S CURRENT STANDARD NOMENCLATURE DIAGNOSIS (INCLUDING ANY COMPLICATIONS)?	
ICD-9-CM (Primary)	DESCRIPTION:
ICD-9-CM (Secondary)	DESCRIPTION:

IS OR WAS THE ILLNESS/INJURY WORK RELATED? ☐YES ☐NO

Give dates of treatments.

Office _____

Hospital _____

Date of Next Scheduled Appointment _____

IS OR HAS THE PATIENT BEEN DISABLED FROM PERFORMING HIS/HER OCCUPATION? ☐YES ☐NO

IF YES, GIVE THE DISABILITY PERIOD: **FROM: _____ TO:**

STATE SPECIFICALLY HOW AND WHY THIS CONDITION PHYSICALLY AND/OR MENTALLY PREVENTS THE PATIENT FROM PERFORMING HIS/HER **NORMAL OCCUPATION**:

Is patient still under your care for this condition? _____If discharged, give date._____

Progress: Recovered ☐ Improved ☐ Unimproved ☐ Retrogressed ☐

IF TOTAL DISABILITY IS CONTINUING, WHEN WILL THE PATIENT BE ABLE TO RETURN TO WORK AT HIS/HER REGULAR OCCUPATION?
PLEASE SUPPLY AN APPROXIMATE DATE. _____/_____/_____

DOCTOR'S NAME	DEGREE	BOARD CERTIFIED SPECIALTY
ADDRESS *(No., Street, City, State, Zip Code)*		
TELEPHONE NO. ( )		TAXPAYER I.D. NUMBER

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

Physician's Signature _____Date _____

DEFINITION OF "DISABILITY" EFFECTIVE FEBRUARY 1, 1989

For purposes of eligibility for continuing benefits due to disability, "disability" or "disabled" shall mean, during the first two years, complete inability to perform their regular duties as an Elevator Constructor Mechanic or Helper. ELIGIBILITY FOR BENEFITS IS SUBJECT TO REVIEW BY N.E.I. HEALTH BENEFIT PLAN. *THIS FORM IS TO BE FURNISHED WITHOUT COST TO THE PLAN*

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 _____

Doctor's Statement

Type of Disability_____

Date of Injury or Illness _____

Date Return to Work _____

Doctor's Signature _____

OFFICE USE ONLY. DO NOT FILL IN.

Last quarter dues paid _____ Quarter granted_____

Executive Board date _____