NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN
PO BOX 477 | NEWTOWN SQUARE, PA 19073-0476
PHONE 1-800-252-4611 | FAX 610-557-4556
weeklyincome@neibenefits.org

WEEKLY INCOME CLAIM FORM

DO NOT USE THIS FORM IF YOUR EMPLOYER IS LOCATED IN NY, NJ, or HI

TO BE COMPLETED BY PLAN MEMBER

Member's Name_____ Last 4 of SSN_____

Street _____ Birth Date _____ Local Union No. _____

City _____ State _____ Zip Code _____ Phone ( )_____

Date I became totally disabled and unable to work _____ Date I last worked before my disability _____

I became totally disabled and unable to work due to ☐ Illness ☐ Accidental Injury (provide details below) Injury Date _____

Describe the nature of your illness or accidental injury causing your inability to work _____

Have you returned to work? ☐ Yes ☐ No Date you returned to work, or anticipated return to work date _____

If your disability is the result of an accidental illness or injury, have you filed, or will you file, a claim with another insurance carrier? ☐ Yes ☐ No

Was your illness or injury caused during the course of your employment? ☐ Yes ☐ No

If your illness or injury was caused during the course of your employment, did you notify your employer? ☐ Yes ☐ No

Have you filed a claim with your Workers Compensation carrier? ☐ Yes ☐ No

If you filed a claim with your Workers Compensation carrier, has your claim been approved? ☐ Yes ☐ No ☐ Unknown

Direct Deposit Election (Traditional Checking Accounts Only)

I elect to have my Weekly Income benefits deposited into my Checking Account ☐ Yes ☐ No

If you elect direct deposit of your Weekly Income benefits, a blank personal check (marked "void") or a direct deposit enrollment form from your banking institution must accompany this form

Bank Routing Number _____ Checking Account Number_____

I am the payee listed above 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.

Federal Tax Withholding Election

In addition to the mandatory Social Security and Medicare tax withholding, I request voluntary Federal tax withholding ☐ Yes ☐ No

If "Yes", please indicate the dollar amount or percentage of Federal tax withholding from each weekly benefit payment $_____ or _____%

I certify that the statements hereon are complete and accurate to the best of my knowledge. I further authorize the release of any medical or employment 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 _____

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.

MEDICAL CERTIFICATION (TO BE COMPLETED BY ATTENDING PHYSICIAN)

Patient's Name _____ Birth Date _____

Date patient was first treated by you specific to this disability _____ Date patient was last treated _____

List the dates the patient was treated by you specific to this disability _____

Diagnosis (nature of the disability which prevents the patient from working) _____ ICD-10 _____

In your opinion, is/was the patient's condition caused by his/her employment? ☐ Yes ☐ No

Date patient became temporarily totally disabled and unable to work _____

Approximate date patient will be able to return to work (do not use "undetermined" or "unknown" please project) _____

Was the patient hospitalized as a result of this disability? ☐ Yes ☐ No Date(s) of hospitalization _____

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

Description of surgical procedure _____ Date of Surgery _____

ATTENDING PHYSICIAN (This statement to be completed at no cost to the 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_____
(Printed Physician's Name)

Address _____ Phone ( )_____
Street

_____ Fax ( )_____
City State Zip Code

Attending Physician's Signature ____ _____ Date _____

TO BE COMPLETED BY CURRENT/LAST EMPLOYER OF RECORD

Employee's Name _____ Last 4 of SSN _____

Employee's last day worked before this disability _____ Date Employee returned to work _____

Employee's last date worked due to ☐ Medical Leave ☐ Layoff ☐ Suspension ☐ Termination ☐ Other _____

Did the Employee's illness or injury occur during the course of his/her employment? ☐ Yes ☐ No ☐ Unknown

If the Employee's illness or injury was related to his/her occupation, was a claim filed with your Workers Compensation carrier? ☐ Yes ☐ No

If a claim was filed with your Workers Compensation carrier, was the Workers Compensation claim approved? ☐ Yes ☐ No ☐ Unknown

Employer Name _____ EIN _____

Address _____ Phone ( )_____Ext._____
Street

_____ Fax ( )_____
City State Zip Code

Completed by _____
Please Print Name & Title

Signature _____ Date _____
I hereby certify that the above information is true and complete to the best of my knowledge

Return to NEIHBP via fax 610-557-4556 or email
weeklyincome@neibenefits.org