INLAND EMPIRE ELECTRICAL WORKERS WELFARE TRUST FUND
DISABILITY CLAIM FORM

WELLPOWER NECA IBEW

INSTRUCTIONS TO EMPLOYEE

1. ☐ ***Review:*** SPD regarding eligibility and rules for these benefits.
2. ☐ ***Complete and sign***: Part 1-Employee's Statement.
3. ☐ ***Physician complete:*** Part 2-Physician's Statement.
4. ☐ Answer all questions to ensure prompt processing.
5. ☐ Mail, fax or email completed form to the Trust Office at the below listed address.

I am applying for: ☐ All Eligible Benefits ☐ Short Term Disability Payments (26 weeks maximum) ☐ Insurance Coverage (6 months maximum)

EMPLOYEE'S STATEMENT

1. Name (print): _____ Date of Birth: _____ Male ☐ Female ☐
   First Middle Last
2. Address: _____
   Number Street City State Zip Code
3. Phone #: _____ Social Security #: _____ Local Union # _____
4. Date last worked: _____ Date returned to work or became available for work: _____
5. Is condition due to injury or illness arising out of ANY employment? Yes ☐ No ☐
6. Are you filing for or now receiving Workmen's Compensation for ANY condition? Yes ☐ No ☐

Is the disability due to an accident? ☐ *No* ☐ *Yes- Please complete #7 & #8*

7. Date accident occurred: Where did accident occur?
8. How did accident occur?

These statements are true and complete to the best of my knowledge. I authorize any Plan Administrator, Insurer, Physician or Hospital to disclose any information regarding my medical benefit coverage, insurance or medical history.

Employee's Signature: _____ Date: _____

PHYSICIAN'S STATEMENT

Patient's Name: _____ Accident Case Yes ☐ No ☐

1a. Diagnosis: _____ Diagnosis Code : _____

Diagnosis Complications: _____

1b. If hospitalized, furnish date of admission: _____ Date of discharge: _____

2. Surgical procedure, if any: _____ Date performed: _____

3. Date of first treatment for this condition: _____ Date of most recent treatment: _____

4. Is patient able to work with this condition during the dates listed on 5a and 5b? Yes ☐ No ☐

5a. Date patient first prevented from working by current condition: _____

5b. Date patient should be able to resume employment: _____

6. In your opinion, is condition due to injury or illness arising out of patient's employment? Yes ☐ No ☐

Doctor's Signature: _____ Date: _____

Doctor's Name (print): _____ Phone # _____

Address: _____
Number Street City State Zip Code

ADMINISTRATOR'S STATEMENT

Eligible: Yes ☐ No ☐ Employer # _____

Date: _____ By: _____

PLEASE MAIL, FAX or EMAIL COMPLETED FORM TO:

Electrical Workers Trust Fund, Attn: Administrator
Email: ieew@rehnonline.com
P O Box 5433, Spokane WA 99205-0433
Phone: 509.534.0600 Toll: 800.872.8979 Fax: 509.535.7883