IBEW LOCAL UNION NO. 654 HEALTH AND WELFARE FUND

DISABILITY CLAIM FORM

ELIGIBILITY INFORMATION MAIL FORM TO: **FRANK M. VACCARO & ASSOC., INC.** ***Actuarial and Administrative Consultants*** ***27 Roland Avenue*** ***Suite 200*** ***Mt. Laurel, NJ 08054-1057*** ***(856-793-2501)***	This is to certify that the employee named below was eligible for benefits on the date incurred. SIGNED:____________________ ADMINISTRATOR DATE:____________________	***CLAIMS PAYING AGENT*** Frank M. Vaccaro & Associates, Inc. Actuarial and Administrative Consultants 27 Roland Avenue Suite 200 Mount Laurel, NJ 08054-1057 (856-793-2501)

DISABILITY CLAIM FORM

EMPLOYEE: Please fill out and sign this portion of your claim statement. Important – failure to fully answer all questions may delay the processing of your claim. Have your doctor complete the "DISABILITY CLAIM FORM" on reverse side and submit this form promptly for eligibility verification as shown above.

1. EMPLOYEE'S NAME (PLEASE PRINT) LAST FIRST MIDDLE	MALE ☐ FEMALE ☐	DATE OF BIRTH MO. DAY YR.	EMPLOYEE SOCIAL SECURITY NO.
2. EMPLOYEE'S STREET ADDRESS	CITY, STATE AND ZIP CODE		TELEPHONE NO.

3. YOUR OCCUPATION	NAME OF EMPLOYER		
4. DATE FIRST DISABLED AND UNABLE TO WORK	NAME AND ADDRESS OF DOCTOR		
5. IS THIS CONDITION DUE TO AN INJURY YES ☐ NO ☐	DATE OF FIRST TREATMENT FOR THIS ILLNESS OR INJURY	DATE OF INJURY	IS THIS CONDITION DUE TO AN OCCUPATIONAL INJURY OR DISEASE? YES ☐ NO ☐
	WHERE DID IT OCCUR?		
6. ARE YOU ENTITLED TO BENEFITS FROM ANY OTHER KIND OF GROUP HEALTH INSURANCE OR PLAN INCLUDING BLUE CROSS & BLUE SHIELD? YES ☐ NO ☐	DESCRIBE HOW ACCIDENT HAPPENED		
	NAME OF OTHER INSURANCE COMPANY AND/OR ORGANIZATION WHERE CLAIMS ARE SUBMITTED		

In consideration of payment of benefits without reduction for any right of recovery under the Disability Act for myself, my heirs, assigns, executors, administrators or personal representatives assign to the IBEW Local #654 Health & Welfare Fund all my right title interest in and to any present or future recovery of disability, however recovered, to the extent of the amount of benefit payments under the IBEW Local #654 Health & Welfare Fund to which I am entitled by reason of such recovery of Disability benefits.

______________________________ __________________

Member's Signature **Date**

(OVER)

DISABILITY CLAIM FORM

ATTENDING PHYSICIAN'S STATEMENT

1. DIAGNOSIS AND CONCURRENT CONDITIONS
(If Diagnosis Code other than ICDA * used, give Name):

2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF A PATIENT'S EMPLOYMENT? *YES* ☐ *NO* ☐

3. Report of services (or Attach Itemized Bill) (If previous form submitted to this carrier, you need show only dates and services since last report)

DATE OF SERVICES	PLACE OF SERVICES	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	PROCEDURE CODE – IF USED (IF CODE OTHER THAN CPT***USED. (Give NAME)	CHARGES
			TOTAL CHARGES	
			AMOUNT PAID	
			BALANCE DUE	

O – Doctors Office IH – inpatient Hospital HN – Nursing Home
H – Patient's Home OH – Outpatient Hospital OL – Other Locations
* ICDA – International
** CPT - Current Procedural Terminology(current edition)

4. DATE. SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED?

5. DATE PATIENTFIRSTCONSULTED YOU FOR THIIS CONDITION

6. PATIENT EVER HAD SAME OR SIMILAR CONDITION?
YES ☐ *NO* ☐ *IF "YES" WHEN AND DESCRIBE:*

7. PATIENT STILL UNDER YOUR CARE FOR THIIS CONDITION

8. PATIENT WAS CONTINUOSLY TOTALLED DASABLED:
(Unable to Work).
FROM THRU

9. PATIENT WAS PARTIALLY DISABLED:
FROM THRU

10. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK?

11. PATENT WAS HOUSE CONFINED:
FROM THRU

12. DOES PATINET HAVE OTHER HEALTH COVERAGE? *YES* ☐ *NO* ☐ *IF "YES" PLEASE IDENTIFY:*

DATE	PHYSICIANS NAME (PRINT)	SIGNATURE
TAX I.D.	DEGREE	TELEPHONE

STREET ADDRESS	CITY OR TOWN	STATE OR PROVINCE	ZIP CODE