IBEW Local 347 Electrical Workers Health and Welfare Fund

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SHORT TERM DISABILITY REPORT

COVERED EMPLOYEE'S NAME _____ SOC. SEC _____

EMPLOYER _____

Part I – Covered Employee Certification (Please answer all questions)

1. Date symptoms first appeared or accident occurred _____
2. I certify that I have been continuously disabled and unable to perform my work since _____ (DATE)
3. Did sickness or injury arise from your employment? ❑ Yes ❑ No
4. Is claim being made for workmen's compensation? ❑ Yes ❑ No
5. My last treatment was on _____ (DATE) by _____ (DOCTOR)
6. I recovered or I expect to recover sufficiently to resume work on _____ (DATE)

I understand that I am required to notify the Fund Office prior to or immediately upon the occurrence of one or more of the following events in accordance with the following rules::

1) I understand that I must provide written notice to the Fund Office before I engage in any employment;
2) I understand that I must provide written notice to the Fund Office prior to the date that I receive unemployment insurance and/or compensation payments;
3) I understand that I must provide written notice to the Fund Office prior to the date that I receive Social Security Disability Benefits;
4) I understand that I must provide written notice to the Fund Office prior to the date that I receive benefits from the National Electrical Benefit Fund; and
5) I understand that I must provide written notice to the Fund Office on the date that a physician determines that I am no longer unable to work because of an injury or sickness.

I hereby certify that all information provided on this Short Term Disability Report is correct to the best of my knowledge. I understand that if this information changes, or if any of the events listed in numbers (1), (2), (3), (4), or (5) above occurs, it is my responsibility to notify the Fund Office immediately. I also understand that I will be required to reimburse the Plan for any payments made as a result of my failure to notify the Fund Office in accordance with the rules described above.

Covered Employee Signature _____ Date _____

Present Address _____ Telephone _____

Part II – Doctor's Certification (Please answer all questions)

1. Diagnosis and Concurrent Conditions _____
2. Date patient first consulted you for this condition _____ (DATE)
3. The patient has been continuously disabled (unable to return to regular work) from _____ (DATE)
4. This Plan does not have a "light" duty release provision. Considering the claimant's occupation, could claimant resume duties of his/her usual and customary work while continuing treatment? ❑ Yes ❑ No
   If no, please explain why _____
   _____
5. The patient recovered, or will recover, sufficiently to return to his regular job on _____ (DATE)
6. Since last report, this patient was hospitalized from _____ to _____
7. Name of Hospital _____
8. Location (City & State) _____
9. Are you still treating patient? ❑ Yes ❑ No
   Date of last treatment _____ Date of next appointment _____
10. Did sickness or injury arise from patient's employment? ❑ Yes ❑ No

Doctor's Signature _____ Date _____

Address _____ Telephone _____