

IBEW HEALTH AND WELFARE TRUST OF SOUTHWEST WASHINGTON  
PO BOX 1747  
Duvall, WA 98019  
(425) 844-9482 (800) 460-2940

**APPLICATION FOR TRUST-PAID COVERAGE DURING DISABILITY**

Both sections that follow must be completed in order for this application to be processed. Failure to do so will result in the rejection of the request, and if qualified, delay the effective date of coverage.

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**TO BE COMPLETED BY EMPLOYEE**

I hereby certify by the evidence attached to this application that I am disabled and unable to perform any work as a electrician. I understand that I will be required to furnish evidence of disability, satisfactory to the Trustees, upon request and at least every three months in order to continue to receive Trust-paid benefits.

Name \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Date Last Worked \_\_\_/\_\_\_/\_\_\_ Employer \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**TO BE COMPLETED BY PHYSICIAN**

I hereby certify that I attended \_\_\_\_\_ on the date(s) listed below and that he/she has been continuously disabled and unable to perform electricians work from \_\_\_\_\_ to \_\_\_\_\_ as indicated below.

INJURY:

ILLNESS:

Nature of injury \_\_\_\_\_ Nature of illness \_\_\_\_\_

Prognosis \_\_\_\_\_ Prognosis \_\_\_\_\_

Date of first treatment \_\_\_\_\_ Date of first treatment \_\_\_\_\_

Date last seen \_\_\_\_\_ Date last seen \_\_\_\_\_

What is the anticipated date of release to return to work \_\_\_\_\_

Name of physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Physician's signature \_\_\_\_\_ Date signed \_\_\_\_\_

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\*\*\*\*\*RETURN COMPLETED FORM TO TRUST FUND ADMINISTRATION OFFICE\*\*\*\*\*

Employee Benefit Administrators, Inc  
PO Box 1747  
Duvall, WA 98019

IBEW HEALTH AND WELFARE TRUST OF SOUTHWEST WASHINGTON

TIME LOSS DISABILITY APPLICATION

DISCLOSURE AUTHORIZATION

CLAIMANT'S NAME (Please Print) \_\_\_\_\_

I authorize: any doctor, hospital, clinic, provider of health care, Insurance (or reinsuring) company, consumer reporting agency, treatment referral service, the Social Security Administration, Medical Information Bureau, Inc., Insured's agent, family members, employer, or any other person or firm having i) information as to diagnosis, treatment, and prognosis of the Claimant's physical or mental condition, or: (ii) any information needed to determine claim benefits with respect to the Claimant: to give to the IBEW Health and Welfare Trust of Southwest Washington (the Trust), it's employees and agents, insured's agent, any consumer reporting agency (including Equifax Service) or any treatment referral service authorized by the Trust, all such information. This includes (but is not limited to): driving records, psychiatric, drug, and alcohol abuse history and treatment.

I understand: the information obtained will be included as part of the proof of claim and will be used by the trust to determine claim benefits with respect to the Claimant. It will not be released to anyone else except a) reinsuring companies; b) Medical Information Bureau, Inc., which operates Health Claim Index (HCL); c) fraud or over insurance detection bureaus; d) anyone performing business, medical or legal functions with respect to the claim; e) as may be required by law; f) as I may further authorize.

I understand that this authorization will be valid during the term of coverage of the Claimant, up to a maximum of one year from the date it is signed.

I may request to receive a copy of this authorization. I also agree that a photo copy shall be as good as the original.

Date Signed \_\_\_\_\_ Claimant's Signature \_\_\_\_\_  
(Or Claimant's authorized representative)

Relationship if other than Claimant \_\_\_\_\_

Claimant's Social Security Number \_\_\_\_\_

IBEW HEALTH AND WELFARE TRUST OF SOUTHWEST WASHINGTON

# Rules and Qualifying Requirements for Trust Paid Medical Benefits

## Qualification:

- 1) The disability must begin during a month when you are eligible as an active participant of the Plan (retiree and COBRA participants do not have this coverage).
- 2) The disability must be extensive enough that you cannot perform the normal duties of an electrician.
- 3) Benefits are payable up to a maximum of 12 consecutive.

## Filing:

- 1) Complete all of the personal information and sign the form. Be sure to complete and sign the "Disclosure Authorization"(last page).
- 2) Have your doctor complete his/her portion of the form and sign it.
- 3) Return all parts of the form to

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## Procedures:

- 1) When your dollar bank can no longer pay the monthly premium and you are still disabled the Trust will pay your monthly premium.
- 2) The monthly premium will be paid until you are released for work and have had sufficient time since your release to have reestablished coverage (whether working or not).
- 3) Benefits will begin on the first day of the month following the last month covered by premium payment from your dollar bank not to exceed twelve (12) consecutive months.