

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 th 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 _____

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Rules and Qualifying Requirements for Weekly Time Loss 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 cannot be job related or subject to an L & I claim.
- 3) The disability must be that you cannot perform the normal duties of an electrician.
- 4) Benefits are payable up to a total of 26 weeks maximum in any 36 month period.

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

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

Procedures:

- 1) Benefits will be paid weekly on Monday of each week.
- 2) The benefit payment amount will be based upon the member’s election to have standard (\$250) or supplemental (\$400) weekly time loss benefits.
- 3) Benefits begin on the 1st day of an accident and on the 8th day of an illness.
- 4) Benefits will be paid up to the “release for work date” indicated by the doctor and may be extended upon written verification of the disability extension by the doctor.