NECA-IBEW WELFARE TRUST FUND

2120 Hubbard Avenue, Decatur, Illinois 62526
Phone: (217) 875-0254 or 800-765-4239

EMPLOYEE STATEMENT
FOR ACCIDENT OR LOSS OF TIME FROM WORK

NOTE TO EMPLOYEE: You must complete this side for any accident or loss of time from work.

1. Employee's social security no. _____

2. Employee's name: _____

3. Address _____ _____ _____ _____
   Street City State Zip

4. Birth date: _____ Sex: M F Local Union # _____ Phone # _____

5. Information on the person who claim is for:

   _____ _____ _____
   Name Relationship to Employee Soc. Sec. #

   _____ _____ Married: Yes No
   Date of Birth Sex

6. If claim is on employee, is there loss of time from work? _____
   (This must be verified by your doctor on reverse side, questions 8 and 9)

7. Date of accident _____ Time _____ A.M. P.M.

   Where did accident occur? _____

   How did accident happen? _____

   _____

   _____

   Was the injury caused by claimant's employment? Yes ☐ No ☐

   Has a claim been filed with Workman's Compensation? Yes ☐ No ☐

8. Have you drawn unemployment since your disability began? Yes ☐ No ☐

   If yes, explain what: _____

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct, and complete. I hereby authorize any physician or any hospital to furnish and disclose all known facts concerning this disability. I will reimburse the Fund for any overpayment made to me or in my behalf due to error on this form.

Employee Signature _____ Date _____

Your Claim Cannot be Processed Without Your Signature

See Reverse Side for Physician's Statement