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

The receipt of forms does not mean eligibility for benefits.

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PHYSICIAN'S STATEMENT FOR ACCIDENT OR LOSS OF TIME FROM WORK

Note to Doctor: ***Please complete for employees only.***

EMPLOYEE'S NAME: _____ EMPLOYEE'S SS#: _____

ADDRESS _____ _____ _____ _____
Street City State Zip

1. Primary Diagnosis (use ICD-9 and/or diagnosis) which employee would be disabled from: _____
   _____
2. Secondary Diagnosis (Use ICD-9 and/or diagnosis), if any: _____
   a. In absence of the primary diagnosis, would employee be disabled from the secondary diagnosis? Yes ☐ No ☐
3. Is this a job related illness or injury? Yes ☐ No ☐
4. If accident, give date occurred: _____
5. If illness, date commenced: _____
6. Date employee first consulted you for this condition: _____
7. Date of hospital confinement, if any: _____
   Name of hospital: _____ Phone #: _____
8. Dates employee was totally disabled (unable to work): From _____ thru _____
9. Date employee released for light duty and any restrictions. From _____ thru _____
   State any restrictions: _____
10. Date employee should be able to return to work: _____
11. What treatment has been given this employee? _____
12. Has physical therapy/occupational therapy been ordered? Yes ☐ No ☐
    If yes, where: _____ Phone # _____
13. Has Cardiac Rehab been ordered? Yes ☐ No ☐
    If yes, where: _____ Phone # _____

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Social Security Number Employer I.D. Number

_____
Physician's Address City/State Zip Phone #

_____ _____ Date: _____
Physician's Name (Please Print) Physician's Signature