

IBU NATIONAL HEALTH BENEFIT PLAN
PMB#116
5331 S MACADAM AVE STE 258
PORTLAND, OR 97239
(800) 547-4457 OR (503) 224-0048 Fax (503) 228-0149 Email ibu@benesys.com

NAME _____
 ADDRESS _____
 SOCIAL SECURITY# _____ PHONE _____

Must be completed for Time Loss Benefits and Waiver of Premium:

- A. Are you receiving, eligible for, or will you be applying for:
- | | | | |
|------------------------------|--------------------------|----------------------------|--------------------------|
| 1. ATO | <input type="checkbox"/> | 6. Jones Act | <input type="checkbox"/> |
| 2. Vacation | <input type="checkbox"/> | 7. Retirement | <input type="checkbox"/> |
| 3. Sick Pay | <input type="checkbox"/> | 8. Unearned Wages | <input type="checkbox"/> |
| 4. Workmen's Compensation | <input type="checkbox"/> | 9. Calif. State Disability | <input type="checkbox"/> |
| 5. Longshore/Harbor Wkrs Act | <input type="checkbox"/> | | |
- If receiving any of the above, for what period? _____

B. Are you receiving any other compensation? Yes No

C. Is the condition due to your employment? Yes No

D. Is the condition due to an accident of any kind? Yes No
 If yes, please advise how, when & where the accident occurred:

E. Were injuries the result of negligence or the intentional act of a third party? Yes No
 If yes, please advise how, when & where the accident occurred:

F. Are/were you hospitalized? Yes No
 If yes, what dates? _____

G. Are you currently working? Yes No

H. Please list your current employer's name, address, & phone number:

I. Are you still disabled? Yes No

I AM APPLYING FOR: Time Loss Disability Waiver of Premium

Signature _____ Date _____

Continued on back....

THE ATTENDING PHYSICIAN MUST COMPLETE THE FOLLOWING SECTION FOR BENEFITS TO BE DETERMINED:

Please advise of the disabling diagnosis: _____

Date employee first consulted you for this condition? _____

Date of last treatment? _____

Frequency of treatment and/or next scheduled treatment? _____

Dates of total Disability: From: _____ through _____

(If return to work date is unknown, please estimate. This may be revised later.)

Please cite the clinical evidence which prevents the employee from working:

Physician's Signature: _____ Date _____

Physician' /Clinic Name, address, & phone number: _____

THIS SECTION MUST BE COMPLETED BY EMPLOYER FOR TIME LOSS

_____ has applied for TIME LOSS benefits through the IBU National Health Benefit Plan. Please answer the following questions and return this form to the above address so we may process the disability claim. If you have any questions, please contact the IBU Trust Office, Claims Dept. @ 1-800-547-4457 X 1651.

1. Is the employee receiving:

ATO	<input type="checkbox"/> Yes <input type="checkbox"/> No	for dates: _____
Vacation Pay	<input type="checkbox"/> Yes <input type="checkbox"/> No	for dates: _____
Sick Leave	<input type="checkbox"/> Yes <input type="checkbox"/> No	for dates: _____
Unearned Wages	<input type="checkbox"/> Yes <input type="checkbox"/> No	for dates: _____
2. Employee's daily shift consists of _____ hours.
3. If this is a work related claim, for which of the following could this employee apply?

Workmen's Compensation	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Longshore & Harbor Worker's Act	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Jones Act	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Is the employee currently working? Yes No
 If yes, when did the employee return to work? _____
5. What state do you pay state unemployment insurance to? _____
 Information verified by: _____

Title: _____ Phone _____ Date _____