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	☐	6. Jones Act	☐
2. Vacation	☐	7. Retirement	☐
3. Sick Pay	☐	8. Unearned Wages	☐
4. Workmen's Compensation	☐	9. Calif. State Disability	☐
5. Longshore/Harbor Wkrs Act	☐		

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

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I AM APPLYING FOR: ☐ Time Loss ☐ Disability Waiver of Premium

_____
Signature Date

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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:_____
_____

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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 [ ] Yes [ ] No for dates:_____
   - Vacation Pay [ ] Yes [ ] No for dates:_____
   - Sick Leave [ ] Yes [ ] No for dates:_____
   - Unearned Wages [ ] Yes [ ] 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 [ ] Yes [ ] No
   - Longshore & Harbor Worker's Act [ ] Yes [ ] No
   - Jones Act [ ] Yes [ ] 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_____

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