# HEALTH PLAN BENEFITS

# TIME LOSS/DISABILITY WAIVER APPLICATION

HARRISON ELECTRICAL WORKERS TRUST FUND
PMB #116
5331 S Macadam Avenue Ste 258
Portland, OR 97239
In Portland Area (503) 224-0048
All Other Locations 1-800-547-4457

**PART 1: MUST BE COMPLETED BY PARTICIPANT**

PARTICIPANT'S FULL LEGAL NAME: ____________________________________________

LAST FOUR DIGITS OF SSN: ____________

ADDRESS: ________________________________________ CITY: ______________

STATE: ______ ZIP: __________ DATE OF BIRTH: ______________

PHONE NUMBER: (______) ____________ EMAIL: ______________________

EMPLOYER: ____________________________________________

WAS THE CONDITION RELATED TO:

A) PARTICIPANT'S EMPLOYMENT

YES ___ NO ___

B) AN ACCIDENT

YES ___ NO ___

IF AN ACCIDENT:

DATE ________20___ AND TIME _______ a.m. / p.m.

DESCRIPTION (HOW AND WHERE):

____________________________________________

____________________________________________

DATE THAT YOU STOPPED WORK: ____________________

DATE YOU EXPECT TO RETURN TO WORK: ______________

ARE YOU APPLYING FOR (CHECK ALL THAT APPLY): TIME LOSS BENEFIT ___ DISABILITY WAIVER ___

HAVE YOU APPLIED FOR PAID LEAVE OREGON/WASHINGTON? YES ___ NO ___

HAVE YOU ALREADY APPLIED FOR THE FMLA BENEFIT? YES ___ NO ___

IF YOU SELECTED NO, PLEASE COMPLETE THE FMLA APPLICATION, WHICH IS ONLINE AT WWW.HARRISONBENEFITS.ORG

PARTICIPANT RELEASE SIGN BELOW*
I HEREBY AUTHORIZE ANY INSURANCE COMPANY, PREPAYMENT ORGANIZATION, EMPLOYER, HOSPITAL OR PHYSICIAN, TO RELEASE ALL INFORMATION WITH RESPECT TO MYSELF WHICH MAY HAVE A BEARING ON THE BENEFITS PAYABLE UNDER THIS OR ANY OTHER PLAN PROVIDING BENEFITS OR SERVICES. I HEREBY CERTIFY THE INFORMATION PROVIDED IS CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE.

X______________________________________________

PARTICIPANT DATE

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## PART 2: TO BE COMPLETED BY THE ATTENDING MEDICAL PROVIDER

| DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT): ______ | DATE FIRST CONSULTED YOU FOR THIS CONDITION: ______ | HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES ___ NO ___ |
|---|---|---|
| DATE PATIENT ABLE TO RETURN TO WORK: | . DATES OF TOTAL DISABILITY: FROM: ____________ THROUGH: ____________ | DATES OF PARTIAL DISABILITY: FROM: ____________THROUGH: ___________ |

FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES:

ADMITTED: ______________________ DISCHARGED: ______________________

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE:

1. ______________________________________
2. ______________________________________
3. ______________________________________
4. ______________________________________

| SIGNATURE OF PHYSICIAN OR SUPPLIER. THE PHYSICIAN MAY ALSO PROVIDE A LETTER ON THEIR OFFICE LETTERHEAD IN PLACE OF A SIGNATURE: | ENTER THE TAXPAYER IDENTIFYING NUMBER TO BE USED FOR 1099 REPORTING PURPOSES. YOU ARE REQUIRED UNDER AUTHORITY OF LAW TO FURNISH YOUR TAXPAYER IDENTIFYING NUMBER. | PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.: |
|---|---|---|
| SIGNED: ____________________________ | ________________________________ | ____________________________________ |
| DATE:______________________________ | | |

## PART 3: DIRECT DEPOSIT AUTHORIZATION: MUST BE COMPLETED BY EMPLOYEE

THE UNDERSIGNED PARTICIPANT (“PARTICIPANT”) HEREBY AUTHORIZES AND DIRECTS THE ADMINISTRATIVE OFFICE FOR THE HARRISON ELECTRICAL TRUST FUND (“PLAN”), TO TRANSFER FUNDS FOR BENEFIT PAYMENTS TO WHICH PARTICIPANT MAY BE ENTITLED UNDER THE TERMS OF THE PLAN AS THEY BECOME DUE AND PAYABLE, AND DIRECTLY DEPOSIT SAID FUNDS BY ELECTRONIC TRASFER TO THE ACCOUNT MAINTAINED BY PARTICIPANT AT THE FINANCIAL INSTITUTION IDENTIFIED BELOW. SAID FUNDS SHALL BE IN FULL PAYMENT, SATISFACTION AND DISCHARGE OF AMOUNTS DUE TO THE PARTICIPANT UNDER THE PLAN. PARTICIPANT AUTHROIZES AND DIRECTS FINANCIAL INSTITUTION TO REFUND ANY PAYMENTS TO THE PLAN TO WHICH PARTICIPANT, OR PARTICIPANT’S SUCCESSORS OR ESTATE, WOULD NOT HAVE BEEN ENTITLED UNDER THE PLAN AS A RESULT OF PARTICIPANT’S DEATH OR OTHERWISE, AND CHARGE THE SAME TO THE PARTICIPANT’S ACCOUNT DESIGNATED BELOW. PARTICIPANT AGREES ON BEHALF OF HIS OR HERSELF, ANY CO-TENANTS, HEIRS, EXECUTORS, SUCCESSORS AND ANY TRUSTEE ON THEIR TRUST (IF ANY) TO REIMBURSE THE PLAN FOR SUCH PAYMENTS.

| ___ CHECKING ACCOUNT | ___ SAVINGS ACCOUNT | ABA ROUTING #: _________________ | ACCOUNT #: ____________________ |
|---|---|---|---|
| DEPOSITORY NAME (BANK, CREDIT UNION, OR FINANCIAL INSTITUTION): ______________________________ | | ADDRESS: CITY: STATE: ZIP: ______________________________ | |

IF THE BANK IDENTIFIED ABOVE IS A FINANCIAL INSTITUTION LOCATED OUTSIDE OF THE UNITED STATES OR THE FUNDS DEPOSITED INTO THE BANK ACCOUNT IDENTIFIED ABOVE WILL BE FORWARDED TO, CREDITED OR OTHERWISE HANDLED BY A FINANCIAL INSTITUTION LOCATED OUTSIE OF THE UNITED STATES, I WILL IMMEDIATELY NOTIFY THE TRUST OFFICE. THIS AUTHORITY IS TO REMAIN IN FULL FORCE AND EFFECT UNTIL THE HARRISON ELECTRICAL WORKERS TRUST FUND HAS RECEIVED WRITTEN NOTIFICATION FROM ME OF ITS TERMINATION IN SUCH TIME AND IN SUCH MANNER AS TO AFFORD THE HARRISON ELECTRICAL TRUST FUND AND THE DEPOSITORY A REASONABLE OPPORTUNITY TO ACT UPON IT. I ACKNOWLEDGE THAT THE ORIGINATION OF ACH TRANSACTIONS TO MY ACCOUNT MUST COMPLY WITH THE PROVISIONS OF U.S. LAW.

x______________________________________________

PARTICIPANT DATE

## HOW TO REQUEST BENEFITS

THIS FORM IS TO BE COMPLETED BY THE PARTICIPANT AND THE ATTENDING MEDICAL PROVIDER:

1) PARTICIPANT COMPLETES **PART 1** - THE PATIENT INFORMATION SECTION
2) ATTENDING MEDICAL PROVIDER COMPLETES **PART 2** - THE "ATTENDING MEDICAL PROVIDER" SECTION.
    - THE PHYSICIAN MAY ALSO PROVIDE A LETTER ON LETTERHEAD IN PLACE OF A SIGNATURE.
3) PARTICIPANT COMPLETES **PART 3** IF THEY WISH TO RECEIVE WEEKLY TIME LOSS BENEFITS VIA DIRECT DEPOSIT
4) PARTICIPANT MUST RETURN THE COMPLETED APPLICATION TO THE BENEFIT OFFICE USING YOUR PREFERRED METHOD BELOW:
    - LOGIN TO WWW.HARRISONBENEFITS.ORG, CLICK ON "DOCUMENTS TO SUBMIT", THEN "TIME LOSS/DISABILITY" AND UPLOAD THE COMPLETED FORM
    - MAIL TO THE TRUST ADMINISTRATIVE OFFICE:
      HARRISON ELECTRICAL WORKERS TRUST
      PMB #116
      5331 S MACADAM AVE STE 258
      PORTLAND, OR 97239
    - FAX THE COMPLETED FORM TO THE BENEFIT OFFICE AT (503) 228-0149