410 Chickamauga Ave
Suite 301
Rossville, GA 30741

Family Medical Care Plan

Phone (706) 841-7000
Toll Free (877) 937-9602
Fax (706) 841-7020
www.nifmcp.com

LOSS OF TIME BENEFIT STATEMENT OF CLAIM

(PARTICIPANT TO COMPLETE THIS SIDE)

Mail to:
NECA/IBEW FAMILY MEDICAL CARE PLAN
410 CHICKAMAUGA AVE, SUITE 301
ROSSVILLE, GA 30741

Participant's Name: ______________________________

Social Security Number: ______________________________

Address: ______________________________

Email Address: ______________________________

Cell Phone Number: ______________________________

Participant's Current or Last Employer: ______________________________

Local Union No.: ______________

Complete if Disability is due to an Illness:

1. Date Symptoms First Appeared: ______________________________
2. Nature of Illness: ______________________________

Complete if Disability is due to an Accident:

1. Date of Accident: ________
2. Location of Accident: ________
3. Give Details of Accident: ______________________________

Is this Disability Due to your Occupation? Yes_____ No_____

Is this Disability Covered by any Workers; Compensation or Occupational Disease Law? Yes _______ No ________

First Full Day Unable to Work ______________________________

Date Resumed Work: ______________________________
Or
Date Expected to Resume Work: ______________________________

Have you been approved for a Social Security Disability Benefit? Yes _____ No ______ Pending _____

Date of Social Security Disability Award: [|] / [|] / [|]
Month Day Year

I certify that the above information is true and correct. I hereby authorize all doctors, hospitals, or other institutions rendering care and treatment to furnish the NECA/IBEW Family Medical Care Plan with full information regarding treatment rendered (including copies of records.)

______________________________ ______________

Signature Date

ATTENDING PHYSICIAN MUST COMPLETE REVERSE SIDE

ATTENDING PHYSICIAN'S STATEMENT

Participant's Name: ____ SSN: __________________

Diagnosis and Concurrent Conditions:

Primary Diagnosis: ______________________________ ICD Code:______

Secondary Diagnoses ____________________________ ICD Code:______

____________________________ ICD Code:______

____________________________ ICD Code: ______

Is Condition due to injury or illness arising out of patient's employment? Yes____No____

Date Symptoms first appeared or accident occurred: ______________________________

Date patient first consulted you for this condition: ______________________________

Has patient every had the same or similar condition? Yes____No____

If "Yes," when and describe: ____

Is patient still under your care for this condition? Yes____No____

For purposes of this form, "Totally Disabled" means the complete inability of the patient to perform each and every duty of his occupation or employment.

Patient has been Totally Disabled starting from ____

and should be able to return to his regular employment on ____.

____ ______________________________

Physician's Signature Date

____

Physician's Name (Print) Degree Telephone Number

____

Street Address City State Zip