IBEW Local 683 Health and Welfare Fund

www.ibew683benefits.org
P.O. Box 39387 St. Louis, MO 63139
Toll Free 844/683-0683 Fax: 314/752-2239

RE: IBEW Local No. 683 Health & Welfare Fund Weekly Disability Benefits

Dear Participant:

Enclosed please find a claim form to be completed for Weekly Disability Benefits through the IBEW Local No. 683 Health & Welfare Fund. You must complete the Participant Statement of the enclosed claim form and sign the authorization to release information.

Your Physician's office must complete and sign and date the Physician's Statement on the claim form. **It is critical that the physician's statement is completed in full to avoid a delay in benefit payment.** Please ensure the physician's statement provides the disability period, estimated return to work date, and diagnosis code of the disabling condition as these are most frequently overlooked fields and benefits cannot be issued until all information is on file.

Please note the Weekly Disability benefits are for a maximum of 39 weeks in the amount of $500 per week. The Plan requires that you be continuously under the care of a physician and require a medical update to be submitted every six (6) weeks while you are not working. It is your responsibility to advise the Service Center of your return-to-work date.

To expedite the processing of this claim, please use the enclosed self-addressed envelope If you have any questions regarding the completion of this claim form, or payment of Weekly Disability benefits, please do not hesitate to contact the Service Center at 844-683-0683.

Sincerely,

Disability Department

Enclosure

SEIU #1 MISSOURI DIVISION

Weekly Disability Claim Form
IBEW Local No. 683 Health and Welfare Fund
P.O. Box 39387
St. Louis, MO 63139

PARTICIPANT STATEMENT (Must be Completed by the participant)

Participant Name:	Social Security #:	Date of Birth:	Home Phone #.
Home Address:	City:	State:	Zip:
Name of Employer:	Employer Phone #:	Is Disability Work Related? ☐ YES ☐ NO	Job Title:

Is the disability the result of an accidentental Injury: ☐YES ☐NO If yes, how.when and where did the accident occur?

Did the injury occur in the course of employment? ☐YES ☐NO

Certification and Authorization to Release Information

I hereby certify that the above information is true and correct to the best of my knowledge. I understand that a falsification or withholding of material facts may result in loss of benefits. For the purpose of determining eligibility for benefits and claim processing, I hereby authorize scBenefitsGroup to receive from and/or provide to medical practitioners, medically-related facilities, insurance companies or like orgazinations or my employer, information as to any physical or mental condition of myself. I know that I have the right to receive a copy of this authorization. I agree a photographic copy is as valid as the origional.

X **X**

Participants Signature Date

PHYSICIAN STATEMENT (Must be completed by attending Physician)

Patients's Name:	Date of First visit for Disabling Condition:
Diagnosis and Concurrent Condition (s):	Is Condition Related to Participants Employment ☐YES ☐NO
If disability is due to pregnancy, expected date of delivery:	If hospitalized, name and address of facility:

Type of surgery? (if applicable) Date surgery performed:

Could the patient resume duties of their occupation during treatment? If no, please explain:

Is the patient currently under your care? ☐ YES ☐ NO
Last appointment: Next Appointment:

Patient is continuously diabled (unable to work) from: to	Patient's estimated return to work:
Physician Name, Tax ID, and Address:	Physician Phone Number:

Signature of Attending Physician: X DateX