



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

## LOSS OF TIME BENEFIT STATEMENT OF CLAIM

Return the completed form by fax to (706) 841-7020, by email to [disabilitysupport@nifmcp.com](mailto:disabilitysupport@nifmcp.com) or by mail to:  
NECA/IBEW Family Medical Care Plan  
410 Chickamauga Avenue, Suite 301  
Rossville, GA 30741

**PARTICIPANT MUST COMPLETE PAGE 1. ATTENDING PHYSICIAN, NURSE PRACTITIONER,  
OR PHYSICIAN ASSISTANT MUST COMPLETE PAGE 2. ALL QUESTIONS MUST BE ANSWERED.**

Participant's Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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 (this does not refer to State Disability Insurance)?

Yes  No  Pending

Date of Social Security Disability award: \_\_\_\_\_

I certify that the above information is true and correct and acknowledge failure to provide accurate information may result in loss of benefits retroactively. I acknowledge that failure to recertify or provide proper documentation may result in overpayment which may be recouped by the Plan, and the Plan has the right to withhold payments on behalf of me and/or my dependents to other providers of benefits through the Plan until the disability overpayment is recouped in full. I authorize all doctors, hospitals, or other institutions rendering care and treatment to furnish the NECA/IBEW Family Medical Care Plan with any and all information regarding treatment rendered (including copies of records related to such treatment).

Signature \_\_\_\_\_ Date \_\_\_\_\_

**STATEMENT BY ATTENDING PHYSICIAN, NURSE PRACTITIONER,  
OR PHYSICIAN ASSISTANT**

Participant's Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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 ever had the same or similar condition?  Yes  No

If "Yes," when and describe: \_\_\_\_\_

Is patient still under your care for this condition?  Yes  No

Is patient receiving inpatient or outpatient care due to their diagnosis?  Inpatient  Outpatient

**For purposes of this form, "disabled" means the patient is unable to work in the trade as a result of an accidental injury or sickness and is completely unable to perform each and every duty of their occupation or employment.**

Patient has been **disabled** starting from \_\_\_\_\_

and should be able to return to their regular employment on \_\_\_\_\_

\_\_\_\_\_  
Physician's Name (Print) Physician's Signature Date

\_\_\_\_\_  
NPI Degree Telephone Number

\_\_\_\_\_  
Street Address City State Zip