LOCAL UNION 212 I.B.E.W.
HEALTH AND WELFARE BENEFIT PLAN
5420 W. Southern Ave, Suite 106
Indianapolis, IN 46241
Phone(513)861-4800 Fax (317) 783-0102

Re: Weekly Disability Income Benefit

Local Union 212 Health and Welfare Benefit Plan's Weekly Disability Income Benefit

The Local Union 212 IBEW Health and Welfare Benefit Plan ("Welfare Plan") offers a Weekly Disability Income Benefit to qualifying participants. Enclosed you will find the following documents relating to the Weekly Disability Income Benefit:

- Application for Weekly Disability Income Benefit
- Eligibility Rules for Weekly Disability Income Benefit
- Subrogation Terms
- Attending Physician's Statement

Please review the enclosed documents carefully. If you believe you are eligible for the Weekly Disability Income Benefit, please have your doctor complete the Attending Physician's Statement and return it, along with your completed Application to the Welfare Plan's office. A self-addressed envelope is enclosed for your convenience. Your doctor may also mail or fax the Attending Physician's Statement directly to the Welfare Plan's office, but you must complete and return your Application to the Welfare Plan for us to begin processing your claim for Weekly Disability Income benefits.[1]

Please note that the Weekly Disability Income benefit is $700.00 per week (minus FICA and Medicare taxes) payable for up to 26 weeks per calendar year. A W-2 Form will be issued to you for tax purposes.

If you have any questions or need additional information regarding the Weekly Disability Income Benefit, please contact the Welfare Plan at (513) 861-4800.

Local Union 212 Sick-Pay Benefit

IBEW Local 212 also provides its members with a Sick-Pay Benefit that is separate from the Weekly Disability Income Benefit and is not administered by the Welfare Plan. For your convenience, enclosed is a HIPAA authorization form that will allow the Welfare Plan's office to share your information with the Union and Business Office if you wish to apply for Sick-Pay Benefits from the Union. Please note that your application for the Weekly Disability Income Benefit is not contingent upon completion of the HIPAA authorization.

The Union's Sick-Pay Benefit will pay $40.00 for the first week of disability and $80.00 for any additional twelve (12) weeks, up to thirteen (13) weeks per calendar year. To qualify for the Union's Sick-Pay benefit, you must be current on dues for the previous 12 months. If you have any questions regarding the Union's Sick-Pay Benefits, please contact the Union's Business Office directly.

[1] If your application for Weekly Disability Income Benefits is denied, you will be notified by the Welfare Plan and will have an opportunity to appeal the decision to deny your application. Please consult the Local No. 212 IBEW Health and Welfare Benefit Plan's Combination Plan Document and Summary Plan Description for more information regarding your benefits and appeal rights.

LOCAL UNION 212 I.B.E.W.
HEALTH AND WELFARE BENEFIT PLAN
5420 W. Southern Ave, Suite 407
Indianapolis, IN 46241
Phone (513) 861-4800
Fax (317) 783-0102

APPLICATION FOR WEEKLY DISABILITY INCOME BENEFITS

Name _____ Social Security No. _____

Address _____
Street City State Zip

Phone Number _____ Employed by _____

Date of Illness/Accident _____ First day unable to work _____

Name of Attending Physician _____
Street City State Zip

Give "details" of injury or illness _____

_____

_____

Was the injury or illness caused by any employment? Yes___ No___. If yes, please state the name of the company you were working for _____

Date you expect to return to work _____Name of Employer _____

Address of Employer _____
Street City State Zip

I understand and acknowledge that the Health and Welfare Fund has an absolute and unconditional right of reimbursement and subrogation for the collection of all benefits paid to me or on my behalf.

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct and complete. I hereby authorize any physician, or any hospital, to furnish and disclose all known facts and records concerning this disability. A photocopy of this authorization shall be valid as the original.

_____ _____
Member's Signature Date

ATTENDING PHYSICIAN'S STATEMENT

In order that we may process the following claim for Disability Income Benefits, we ask that you supply us with the information as requested on this form. If you have any questions, please feel free to call the Health and Welfare Benefit Plan at (513) 861-4800.

Does the above report concur with your diagnosis? Yes___ No___

Please give details according to your observation and records _____

_____

_____

Is the patient still under your care for this condition? Yes___ No___

The patient was continuously and totally disabled (unable to work) from _____ to_____

If the patient was only partially disabled, please give dates of disability _____ to

_____

Date when patient will be able to return to full-time work _____

Additional information, if any, you feel relevant to this claim _____

_____

_____

_____ _____ _____

Signature (Must be an M.D. or D.O.) Date Federal ID. #

WEEKLY DISABILITY INCOME BENEFITS

Weekly benefits are payable if *you* become totally disabled while *you* are eligible for this benefit. These weekly benefits are for *eligible employees* only. Retirees and members who qualified for coverage under the accelerated eligibility rules are not eligible for weekly disability income benefits.

You are not eligible for weekly benefits if *You* become disabled while *you* are making self-payments for COBRA coverage.

WEEKLY DISABILITY INCOME BENEFIT

If you are eligible to receive a Weekly Disability Income Benefit in accordance with the provisions and conditions under the Plan, you will receive a benefit in the amount of $700.00 weekly, less applicable withholdings.

DEFINITION OF TOTALLY DISABLED

You are considered to be totally disabled if, as a result of non-occupational accidental bodily injury or sickness, *you* are completely unable to work at the electrical trade or a related occupation for which *your employer* has made *contributions* to the *Fund* on *your* behalf.

ELIGIBILITY FOR WEEKLY BENEFITS

Requirements To Be Eligible For Weekly Benefits:

1. *You* must have met the initial eligibility requirements; and

2. *You* must have worked at least 200 hours (in the 6 months preceding the disability) of the required hours in the previous eligibility period; and

3. At the time *you* are disabled:

    - *You* must be gainfully employed under the *CBA* between the Local 212 and the signatory *employers*, or
    - *You* must be employed by any member of a reciprocal agreement in which Local No. 212 is a member, or
    - *You* must be gainfully employed by an *employer* that is party to a participation agreement with the *Plan* that requires contributions to be made on your behalf; or
    - *You* must have gained eligibility in this Local Union No. 212, IBEW Health and Welfare benefit *Plan* and be employed in another local's jurisdiction, and
    - *You* must apply for benefits within 30 days of the start of *your* disability and submit the proper forms to the *Administrative Manager*. (If *you* apply for benefits more than 30 days after *your* disability starts, benefits will not begin until the first week following the date *your* claim is received.)

Exceptions:
If *you* are not employed when *your* disability starts and *you* are on the Local No. 212's referral list and *your* name reaches the No. 1 position but *you* cannot work because of the disability, *you* will be eligible for weekly benefits if *you* worked the required number of hours in the previous eligibility period.

If *you* are not employed when *your* disability starts and *you* are hospitalized due to the disability, *you* may still be eligible to receive weekly benefits during the hospital confinement if *you* are otherwise eligible for weekly benefits and *your* unemployment is due to lack of work.

If, during *your* disability, it appears that *you* are gainfully employed, even in alternative employment, and *you* are being compensated for the services, the *Trustees* will determine *your* eligibility for weekly benefits based on the facts of *your* case. As a general guideline, *you* will be eligible to receive weekly benefits if *you* are not performing *your* customary duties at the electrical or a related trade and *your* disability is certified by a doctor who is an M.D. or D.O, physician assistant, or nurse practitioner.

PROOF OF DISABILITY

A certificate indicating that *you* are unable to work, signed by a doctor who is an M.D. or D.O., physician assistant, or nurse practitioner is required before benefits will be paid. The Plan will not accept certification from a chiropractor. *You* can contact the *Administrative Manager* for the proper form. A disability will not be considered to have begun until the first day that *you* are actually examined or treated by a doctor.

The Plan requires the following information supporting any disability claim, to be supplied at your expense:

1. The date of the disability;

2. The cause of the disability;

3. The prognosis of the disability;

4. Proof that you are receiving appropriate and regular care for the condition from a licensed doctor (excluding a chiropractor), physician assistant, or nurse practitioner who is someone other than you or a member of your immediate family and whose specialty or expertise is the most appropriate for the disabling condition(s);

5. A description of the extent of the disability, including restrictions and limitations which are preventing you from performing your regular occupation; and

6. The name and address of any hospital or medical facility where you have been treated for the disability.

CONTINUING PROOF OF DISABILITY

You may be asked to provide proof that you continue to be disabled and are receiving appropriate and regular care from a doctor, physician assistant, or nurse practitioner. Requests for continuing proof of disability will be made only as often as the Board of Trustees deems reasonably necessary and must be

satisfied at your expense within 30 days of the Board's request. If you fail to comply with a request for continuing proof of disability, your benefits may be delayed, suspended or terminated.

The Board may also require you to be examined as often as reasonably necessary while the weekly income disability claim continues. Such an examination will be done at the Board's expense by a board-certified doctor of the Board's selection. Further, the Board may examine any and all hospital or medical records relating to the injury or sickness underlying your short-term disability claim.

PAYMENT OF BENEFITS

When Benefits Begin: The amount of *your* weekly benefit is shown on the Schedule of Benefits. Benefits are paid only for full calendar weeks of disability, Monday through Friday. Benefits are not paid for partial calendar weeks of disability. *You* will receive one benefit check a week which may be paid via direct deposit upon request.

For example, if a disability due to injury begins on a Monday, *you* will be issued a check on Friday of that week for the full week. But if the disability begins on a Wednesday, no payment is made for that partial week. *You* will be issued a check on Friday of the next week (9 days later). If the disability is due to sickness, *you* will be issued a check for the next full week after the first full calendar week of disability.

A recurring injury will be treated as a sickness for determining when benefits start. A hernia will be considered a sickness unless *you* are hospitalized on the day of occurrence of the hernia. If *you* are a female *employee* disabled as the result of maternity or a pregnancy or a pregnancy-related condition, that disability will be considered a disability due to sickness.

Maximum Benefit Period: Weekly benefit are payable for up to 26 weeks during a 12-month period. A 12-month period starts on the day *you* report sick or injured. *You* cannot receive weekly benefits for another disability until 12 months have gone by since the beginning of the previous disability and *you* have returned to work for one eligibility period and worked at least 200 hours.

Overpayments: If you receive weekly disability income benefits when ineligible for such benefits, you must immediately notify the *Administrative Manager* and return any overpayments. The Board may choose the method of recovery for any overpayments.

RECURRENCE OF DISABILITY

The waiting week(s) will not apply to a period of total disability caused by a recurrence of a total disability for which Weekly Disability Income Benefits were paid if the subsequent period of disability meets all of the following requirements:

1. The disability recurs after less than fourteen days;

2. The second period, or any subsequent period, of disability is due to the same cause as the previous disability; and

3. *You* did not return to work during the intervening period against medical advice.

FRAUD

Any person who knowingly and with intent to defraud provides false information or omits relevant facts when filing a claim may be subject to criminal and civil penalties. These penalties include, but are not limited to, fines, denial or termination of benefits, recovery of any amounts paid, civil damages and/ or criminal prosecution.

EXCLUSIONS AND LIMITATIONS (LOSSES NOT COVERED)

Weekly Benefits will not be paid for:

1. Any disability which results from a sickness or injury for which *you* are not under the direct care of a doctor, physician assistant, or nurse practitioner;

2. Any disability which starts while *you* are maintaining *your* eligibility by making self-payments for COBRA coverage;

3. Any disability for which *you* are entitled to receive benefits in whole or in part under any Workers' Compensation law, Occupational Diseases law or similar law, unless *you* have executed an appropriate subrogation agreement;

4. Any period of the disability during which you are eligible for salary continuation, sick pay, vacation or similar benefits that allow you to maintain your regular income; or

5. Any disability that results from injury sustained while performing any act or duty pertaining to any occupation or employment.

For additional exclusions and limitations that apply to the Weekly Disability Income Benefit, refer to the "Plan Conditions, Limitations and Exclusions" section in this SPD.

TAXATION OF WEEKLY BENEFITS

You must include *your* weekly Disability Income Benefits in *your* gross income and pay federal income tax on them. If *you* have a question about this, or about exclusions in the law, *you* should check with a competent tax advisor or counsel.

Weekly Income Benefits are also subject to Social Security taxes (FICA). *You* pay half of the tax and *the Plan* pays half. In accordance with federal law, the *Plan* will withhold *your* share of the FICA tax from each weekly benefit paid to *you* and will send it to the government.

RIGHT OF RECOVERY

The *Plan* reserves the right to recover benefit payments made for an allowable expense under the *Plan* in the amount that exceeds the maximum amount the *Plan* is required to pay under these provisions. This right of recovery applies to the *Plan* against:

1. Any person(s) to, for or with respect to whom, such payments were made; or

2. Any other insurance companies, or organizations that according to these provisions, owe benefits due for the same allowable expense under any other plan.

The *Board of Trustees* has sole discretion in deciding against whom this right of recovery will be exercised.

REIMBURSEMENT/SUBROGATION

Subrogation and reimbursement allows the *Fund* to recoup the value of any benefits (medical, disability, etc.) paid on behalf of a person covered by this *Plan* who is injured or suffers an illness through the act or omission of another person or entity accountable for the injury or illness (hereinafter called "Accountable Person" or "Accountable Persons"). The subrogation and reimbursement process helps the overall financial stability of the *Fund* by ensuring that the *Plan* is not the only entity paying claims for illness and injuries caused by Accountable Persons.

By accepting benefits from the *Fund*, every *covered person* shall be deemed to have conclusively agreed to cooperate with the *Fund* to enforce its subrogation and reimbursement rights and to hold any recovery in trust for the benefit of the *Fund* in accordance with the terms of this *Plan*:

1. The *Plan* shall be repaid the full amount of the *covered expenses* it pays from any amount received from an Accountable Person for the *bodily injuries* or losses that necessitated such *covered expenses*. Without limitation, "amounts received from an Accountable Person" specifically includes, but is not limited to, liability insurance, workers' compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments, and any other settlements, judgments or insurance proceeds from any source in connection with the illness or accident. The *Plan's* rights apply to any recovery for any *covered person* regardless of whether the amounts are characterized or described as medical expenses or as amounts other than for medical expenses.

2. The *Plan's* right to repayment is, and shall be, prior and superior to the right of any Accountable Person, including the *covered person*, and the *Plan's* subrogation and reimbursement rights shall apply on a priority first-dollar basis to any recovery whether by suit, settlement, or otherwise even though the *covered person* may not have been fully compensated or "made whole" for all physical, psychological and/or financial damages. This provision rejects any "make whole" doctrine which would require a *covered person* to be "made whole" before the Plan is entitled to assert its subrogation rights.

3. The right to recover amounts from an Accountable Person for the injuries or losses that necessitate *covered expenses* is jointly owned by the *Plan* and the *covered person*. The *Plan* is subrogated to the *covered person's* rights to that extent. Regardless of who pursues those rights, the funds recovered shall be used to reimburse the *Plan* as prescribed above; the *Plan* has no obligation to pursue the rights for an amount greater than the amount that it has paid, or may pay in the future. The rights to which the *Plan* is subrogated are, and shall be, prior and superior to the rights of any Accountable Person, including the *covered person*. Any recovery, regardless of the source, must be held in trust by the *covered person* for the benefit of the *Plan.*

4. The *covered person* will cooperate with the *Plan* in any effort to recover from a Accountable Person for the *bodily injuries* and losses that necessitate *covered expense* payments by the *Plan*. The *covered person* will notify the *Plan* immediately of any claim asserted and any settlement entered into, and will do nothing at any time to prejudice the rights and interests of the *Plan.*

Neither the *Plan* nor the *covered person* shall be entitled to costs or attorney fees from the other for the prosecution of the claim.

5. The Plan's rights of reimbursement and subrogation shall not be affected, reduced or eliminated by the make whole doctrine, comparative or contributory fault or the common fund doctrine, or any other federal or state common law defense.

6. The Plan is entitled to recover *your* debt to the Plan (such as, but not limited to, instances of overpayment) by offsetting future employer contributions.

RIGHT TO COLLECT NEEDED INFORMATION

You must cooperate with the *Administrative Manager* and when asked, assist the *Administrative Manager* by:

1. Authorizing the release of medical information including the names of all providers from whom *you* received medical attention;

2. Obtaining medical information and/or records from any provider as requested by the *Administrative Manager* ;

3. Providing information regarding the circumstances of *your sickness* or *bodily injury*;

4. Providing information about other insurance coverage and benefits, including information related to any *bodily injury* or *sickness* for which another party may be liable to pay compensation or benefits; and

5. Providing information the *Administrative Manager* requests to administer the *Plan.*

Failure to provide the necessary information will result in denial of any pending or subsequent claims, pertaining to a *bodily injury* or *sickness* for which the information is sought, until the necessary information is satisfactorily provided.

The *covered person* must sign forms assigning subrogation and reimbursement rights to the *Plan.* The *Administrative Manager* may withhold payment of any benefits due under the *Plan* until it receives the signed forms. Payment of *Plan* benefits before the signed forms are received does not modify or invalidate the *Plan's* subrogation and reimbursement rights. By accepting benefits from the *Plan*, every *covered person* shall be deemed to have conclusively agreed to cooperate with the *Plan* to enforce its subrogation and reimbursement rights, and to hold any recovery in trust for benefit of the *Plan.*

DUTY TO COOPERATE IN GOOD FAITH

You are obliged to cooperate with the *Administrative Manager* in order to protect the *Plan's* recovery rights. Cooperation includes promptly notifying the *Administrative Manager* that *you* may have a claim, providing the *Administrative Manager* relevant information, and signing and delivering such documents as the *Administrative Manager* reasonably request to secure the *Plan's* recovery rights. *You* agree to obtain the *Plan's* consent before releasing any Accountable Person from liability for payment of medical expenses. *You* agree to provide the *Administrative Manager* with a copy of any summons, complaint or any other process serviced in any lawsuit in which *you* seek to recover compensation for *your bodily injury* or *sickness* and its treatment.

You will do whatever is necessary to enable the *Administrative Manager* to enforce the *Plan's* recovery rights and will do nothing after loss to prejudice the *Plan's* recovery rights.

You agree that *you* will not attempt to avoid the *Plan's* recovery rights by designating all (or any disproportionate part) of any recovery as exclusively for pain and suffering.

Failure of the *covered person* to provide the *Administrative Manager* such notice or cooperation, or any action by the *covered person* resulting in prejudice to the *Plan's* rights will be a material breach of this *Plan* and will result in the *covered person* being personally responsible to make repayment. In such an event, the *Plan* may deduct from any pending or subsequent claim made under this *Plan* any amounts the *covered person* owes the *Plan* until such time as cooperation is provided and the prejudice ceases.

TRUSTEES' DISCRETION

Even though the subrogation rights of the *Fund* are specifically and unequivocally due from the first dollar received by the *covered person*, the *Plan* reserves the right to exercise judgment as to the facts of each case. In determining each individual case, even though the *Fund* has the right to recover from the first dollar received, the *Trustees* may consider and allow for the cost of collection from the Accountable Person, including reasonable attorney's fees incurred by the *covered person*, in the sole discretion of the *Trustees*.

GENERAL PROVISIONS

The following provisions are to protect *your* legal rights and the legal rights of the *Plan*.

CONTESTABILITY

The *Plan* has the right to contest the validity of *your* coverage under the *Plan* at any time.

RIGHT TO REQUEST OVERPAYMENTS

The *Plan* reserves the right to recover any payments made by the *Plan* that were:

1. Made in error; or

2. Made to *you* or any party on *your* behalf where the *Plan* determines the payment to *you* or any party is greater than the amount payable under this *Plan*.

The *Plan* has the right to recover against *you* if the *Plan* has paid *you* or any other party on *your* behalf. This includes (a) offsetting the amount against any future medical claims for which you and/or your dependent(s) may be entitled to have paid for by the Plan; (b) retaining Employer Contributions to the Plan made on your behalf; and/or (c) bringing a civil action.

WORKERS' COMPENSATION NOT AFFECTED

The *Plan* is not issued in lieu of, nor does it affect any requirement for coverage by any Workers' Compensation or Occupational Disease act or law.

WORKERS' COMPENSATION

If benefits are paid by the *Plan* and the *Plan* determines *you* received Workers' Compensation for the same incident, the *Plan* has the right to recover as described under the Reimbursement/Subrogation provision. The *Plan* will exercise its right to recover against *you* even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;

2. No final determination is made that *bodily injury* or *sickness* was sustained in the course of or resulted from *your* employment;

3. The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by *you* or the Workers' Compensation carrier;

4. The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by the *Plan*, *you* will notify the *Administrative Manager* of any Workers' Compensation claim *you* make, and that *you* agree to reimburse the *Plan* as described above.

CONSTRUCTION OF PLAN TERMS

The *Plan* has the sole right to construe and prescribe the meaning, scope and application of each and all of the terms of the *Plan*, including, without limitation, the benefits provided thereunder, the obligations of the *covered person* and the recovery rights of the *Plan*; such construction and prescription by the *Plan* shall be final and uncontestable.

LOCAL UNION 212 I.B.E.W.
HEALTH AND WELFARE BENEFIT PLAN

Member _____

Date of Accident _____

SUBROGATION ASSIGNMENT

To the extent of benefits provided by Local Union No. 212 IBEW Health and Welfare Trust (herein called Trust) we hereby assign, transfer and set over the said Trust, which is hereby subrogated to, any and all rights of recovery which we may have, or ought to have, against any person, firm or corporation legally responsible to pay for medical bills or compensation for injury, illness, disease, or condition to the person or persons listed below as patient(s).

We hereby warrant that we have made no settlement, with any person or firm or corporation, against whom we may have a claim or right of recovery, and that we have given no release to any person, firm or corporation whose negligence, or wrongful act may have caused such injury, illness, disease or condition and that we will not make any settlement with or give any release to any such person, firm or corporation without the written consent of LOCAL UNION 212 I.B.E.W. HEALTH AND WELFARE FUND.

This subrogation assignment means that you must repay the Health & Welfare Fund all money that the Fund has paid to you or on your behalf to the extent of money that you receive from any other source.

Signature of Person(s) Injured: _____

_____

Date: _____

Signature of Member (if not person injured):_____

Date: _____

Date of Accident: _____

AUTHORIZATION TO REVIEW INDUSTRIAL COMMISSION CLAIM FILE

Claimant: _____

Social Security No.: _____

Claim No.: _____

Employer: _____

I, _____, hereby authorize the Administrator of the Local Union 212 Health and Welfare Fund or his duly recognized representative to review the Industrial Commission file which is referenced above and known as Claim No. _____.

Signature: _____

Date: _____

CINCINNATI CHAPTER NECA & LOCAL UNION 212 I.B.E.W.
HEALTH AND WELFARE FUND
ACCIDENT QUESTIONNAIRE

1. NATURE OF ACCIDENT: (auto, boat, fall, etc.) _____
2. DETAILS OF ACCIDENT: (describe fully using an additional sheet if necessary) _____
3. NAME OF YOUR INSURANCE COMPANY: (auto, homeowners, etc.) _____
4. NAME AND ADDRESS OF YOUR AGENT: _____
5. POLICYHOLDER'S NAME AND POLICY NO.: _____
6. NAME OF OTHER PARTY AT FAULT (driver of other car if auto accident): _____
7. THEIR ADDRESS: _____
8. NAME OF OTHER INSURANCE COMPANY: (auto, homeowners, etc.) _____
9. NAME OF AGENT AND ADDRESS: _____
10. **A.** IF AUTO ACCIDENT, WERE DETAILS REPORTED TO POLICE: ___YES ___NO
    B. IF YES, NAME AND ADDRESS OF POLICE DEPARTMENT:
11. WAS A CITATION ISSUED: ___YES ___NO
    TO WHOM ISSUED: _____
12. HAVE INSURANCE COMPANIES OF ALL PARTIES BEEN NOTIFIED: ___YES ___NO
13. DOES OTHER PARTY'S INSURANCE COMPANY PROVIDE BENEFITS FOR PERSONAL INJURY: ___YES ___NO
14. DO YOU INTEND TO FILE SUIT TO COLLECT FOR PERSON INJURIES: ___YES ___NO
15. PLEASE STATE NAME AND ADDRESS OF ANY ATTORNEY REPRESENTING YOU ON THIS CLAIM:
16. REMARKS (FURNISH ANY OTHER INFORMATION REGARDING ANY ACTION, AGREEMENT OR JUDGEMENT NOW BEING COMTEMPLATED OR CONCLUDED): _____
17. DATE OF ACCIDENT: _____
18. LOCATION OF ACCIDENT: _____
19. NAMES OF OTHERS IN YOUR FAMILY INJURED: _____

_____ _____
Date Signature of Member

Authorization for the Release of Protected Health Information("PHI")
Local Union No. 212 IBEW Health and Welfare Fund "Plan"

Submit form to:
Fax: (702)216-0885, **or Mail**: IBEW 212, Privacy Officer, 100 Crescent Centre Parkway, suite 340, Tucker, GA 30084-7064

This form authorizes the release of PHI by: ***Zenith American Solutions, the third-party administrator for the Plan.***

THIS FORM IS VOLUNTARY–SUBMIT ONLY IF YOU WANT TO AUTHORIZE A PERSON/ORGANIZATION ACCESS TO YOUR INFORMATION. ***PLEASE CAREFULLY READ THE DIRECTIONS AND PRINT CLEARLY. ANSWER ALL APPLICABLE QUESTIONS.***

1) Employee/Participant

Last Name	First Name	Date of Birth (mm/dd/yy)	Last 4 digits of SSN # or Member ID #	Phone

Address	City	State	Zip

2) Individual whose PHI is to be released, **required only if it's the spouse or dependent's information to be released.**

Individual's Full Name (only one individual permitted per Authorization)	Relationship to Employee	Date of Birth (mm/dd/yy)	Phone

3) Person or organization (or class of persons/organizations) authorized to receive the PHI

Name: _____ Relationship *(e.g., spouse, lawyer, etc.)*: _____

4) Describe the PHI to be used or disclosed

☐ Any/All Information **OR**

☐ Claims ☐ Eligibility ☐ Appeals ☐ Payment-Related (Include dates, if applicable) _____

☐ Other (specify): _____

5) Indicate the specific purpose of the Authorization

☐ At my request **OR** ☐ for a different purpose (specify): _____

6) This Authorization will expire (choose one)

☐ When I revoke it in writing **OR** ☐ On this date OR event: _____

Important Information About Your Rights - I have read and understand the following statements about my rights:

- This authorization is voluntary, and I may refuse to sign it.
- I may revoke this authorization at any time prior to its expiration date by sending a written revocation notice to the Privacy Officer at the address at the top of the form. The revocation will not have any effect on any actions that the entity took before it received the revocation notice.
- I am not required to sign this authorization as a condition to receive treatment or payment for health care; enrolling in a health plan; or establishing eligibility for benefits.
- The information that is used or disclosed pursuant to this authorization may be redisclosed by the receiving person or organization and, upon redisclosure, no longer be protected by federal privacy laws.

7) Signature of Individual or Personal Representative* making the request

By signing below, I am authorizing the release of the information stated in this Authorization.

I am: ☐ the Employee ☐ Adult Dependent or Spouse ☐ Parent/Guardian* ☐ Legally Authorized*

Print Name	**Signature**	**Date**
Address/Phone, *if different from Employee*:	Address	Phone

***PERSONAL REPRESENTATIVE -** A *personal representative* is someone who has authority under applicable law to act on someone's behalf, such as a parent or guardian of a minor child, or an attorney-in-fact designted by a Durable Power of Attorney "POA". If the covered parent signs the Authorization on behalf of their dependent minor, legal documentation is not required. Documentation is required if signing pursuant to a legal designation; please submit a copy of such legal documentation *(e.g. a POA, designation of Guardianship or Estate Trustee).*

Instructions for Completion of

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION ("PHI") FORM

All sections on the form require a response. Please print legibly. Failure to complete all sections will result in denial of the request and return of the form for correction.

<u>THIS FORM IS VOLUNTARY</u> – Complete only if you want to authorize another person or organization to have access to your information.

1. **Employee/Participant** – **REQUIRED**: Provide information about the account holder/ employee/participant. We require this information to locate the individual in our systems.

2. **Individual whose information is to be released – required only if it's the spouse or dependent's information to be released.**: Whose information is to be shared? If it is the employee/participant, leave blank. If it is a dependent (spouse, adult, or minor child), provide their information. *Only one individual is permitted per Authorization.*

3. **Person or organization (or class of persons/organizations) authorized to receive the information – REQUIRED**: This is the person or organization to whom you are permitting the plan to release protected health information. *(Examples: John Doe, spouse; XYZ Law Firm)*

4. **Describe the information to be used or disclosed – REQUIRED**: Check *"Any and All"* **or** specify what type of information can be released. *(Examples: claims information from 2020-2025; eligibility and billing information, etc.)*

5. **Indicate the purpose of the Authorization – REQUIRED:** You may check *"At my request"* or write your own purpose. *(Examples: "To discuss benefits with the Trust Fund so I can better understand my benefits", or "My spouse helps me with my EOBs and bills.")*

6. **This Authorization will expire (choose one) – REQUIRED:** Include a specific date or event for which you want the Authorization to expire. Check *"Until I revoke in writing"* **or** write in a specific date or event *(Example: "Upon termination of enrollment in the health plan"*).

7. **Signature of Individual or Personal Representative* making the request – REQUIRED:** Check the appropriate box to indicate who is signing the form. The Authorization must be signed and dated:

    - By the individual whose information is being released **if the individual whose information is being released is of legal age in their state of residence, <u>or</u>**
    - By the individual's Personal Representative If the Authorization is being signed *on the individual's behalf.*
        - A *personal representative* is someone who has authority under applicable law to act on someone's behalf, such as a parent, guardian, or durable power of attorney. <u>Please submit a copy of such legal document, if applicable</u> *(for example, a Power of Attorney, Guardianship documentation)*.
        - If the participant is signing the Authorization on behalf of their dependent minor, legal documentation is not required.

DISABILITY BENEFIT ELECTRONIC FUND TRANSFER (EFT) REQUEST

COMPLETE THIS SECTION IF YOU WANT DISABILITY PAYMENTS DEPOSTED DIRECTLY INTO AN ELIGIBLE CHECKINGS OR SAVINGS ACCOUNT

I REQUEST MY WEEKLY BENEFIT BE SENT TO MY BANK (OR OTHER FINANCIAL INSTITUTION SHOWN BELOW) FOR ELECTRONIC FUNDS TRANSFERS.

I. NAME:_____ SOC. SEC. #: _____
(Please Print) (last 4 digits only)

ADDRESS _____

_____
(City) (State) (Zip)

TELEPHONE NUMBER (_____)_____Email Addr:_____

If this is a NEW address, please check here ___

II: FINANCIAL INSTITUTION
Name_____Phone Number(____)_____

Branch Mailing Address _____

_____
(City) (State) (Zip)

ACCOUNT NUMBER (please check **only** one) **We can NOT direct deposit to a debit card**. Please provide your checking or savings account information only.

_____ Checking Account: My account number is _____
***Attach a "voided" check**
Please provide the 9 digit Bank Routing Number if it differs from your voided check: _____

"OR"

_____ Savings Account: My account number is:_____

***Attach a deposit slip, if available**
Please provide the 9 digit Bank Routing Number if it differs from your voided check:_____

As benefit payments become payable, I authorize the Administrative Office to pay by directing the electronic transfer of funds, to the order of the above named financial institution for credit to my account. I authorize said financial institution to refund an amount equal to any payment, which becomes due after my death that has been credited to my account or to charge the account accordingly. In addition, in the event of an incorrect amount or entry, I authorize the Administrative Office to reverse this transaction. I reserve the right to cancel this authorization and direction by giving written notice to the Administrative Office.

I will notify the Administrative Office when I change my permanent residence and advise at that time if payments are to continue to be sent to the financial institution named above.

Signature_____ Date _____