ELECTRICAL WORKERS LOCAL 369
BENEFIT AND RETIREMENT FUND
906 MINOMA AVENUE
LOUISVILLE, KY 40217

PHONE:502-635-2611
FAX:502-637-3444
TOLL FREE: 800-427-2495

Applying for Weekly Disability

Dear Member:

The Weekly Disability benefit will protect you and your family in the event a non-occupational injury renders you temporarily disabled. This benefit is available only to Active Employees.

To apply for the Weekly Disability benefit you must submit the enclosed forms:

- **APPLYING FOR WEEKLY DISABILITY**
- **HIPAA AUTHORIZATION**
- **PHYSICIAN CERTIFICATION**

The **HIPAA AUTHORIZATION** form (enclosed) gives your physician permission to share your health information with the Fund and permission for the Fund to use this information in determining your benefit. Please have your physician complete this form and fax or mail to the Benefit Fund Office.

You will receive a **NOTICE OF DECISION** from the Fund Office within 45 days of receipt of your claim. If the Fund Office needs more time or information, you will receive a written request within 45 days.

When a decision is made on your Disability claim, if approved, the Plan pays the benefit every two weeks for up to 13 weeks, as long as you continue to be unable to work. You are not responsible for self-payment contributions during this time. Every two weeks, you must submit an updated **PHYSICIAN CERTIFICATION** form.

For details about your benefits, refer to your Summary Plan Description (SPD) or call the Fund Office at 502-635-2611 or 800-427-2495.

Sincerely,

Administrative Manager

Applying for Weekly Disability

Complete and send this form to the Fund Office when you are applying for Weekly Disability benefits.

Regulations

You are eligible to receive this benefit when a non-work-related event has caused you to be temporarily disabled. If you are eligible, benefits begin on the eighth day of your absence due to sickness or the first day of your absence due to injury. You are eligible for up to 13 weeks as long as you continue to be unable to work.

Forms

You must provide your physician with your completed **HIPAA AUTHORIZATION**. This form gives your physician permission to share your health information with the Fund and permission for the Fund to use this information in determining your benefit.

Provide your doctor a **PHYSICIAN CERTIFICATION** form and ask him or her to complete and fax to the Fund Office. You must submit an updated Physician Certification, confirming that you are disabled, every two weeks.

Documentation

Any documentation that proves you are temporarily disabled will be considered in the decision.

You may return forms and documentation to the Fund Office by mail, fax, or email.

Mail
Electrical Workers Local 369 Benefit Fund
906 Minoma Ave.
Louisville, KY 40217

Fax
502-637-3444
Use the cover page provided

Email
mwendler@369benefits.com

Contact the Fund Office for more information about your benefits.

1-502-635-2611 or

1-800-427-2495

Employee Name		Today's date	
Social Security number		Primary phone number	
Date of birth		Email address	
Home address	City	State	Zip code
What is the nature of your disablement?			
What was the event that caused you to be temporarily disabled?			
What is the date of the event that caused you to be temporarily disabled?			

By signing this form, I affirm that, to the best of my knowledge, the information I am providing is true and accurate. I am aware that the Plan provisions are provided in the Electrical Workers Local 369 Benefit Fund Plan Document. If there is a discrepancy between the wording here and the Plan Document, the language in the Plan Document governs. I acknowledge that the Trustees reserve right to interpret, amend, modify or terminate this Plan or any of the benefits at any time.

Employee signature _____ Date _____

HIPAA Authorization

Consent to Obtain Health Care Information

HIPAA is an acronym that stands for the Health Insurance Portability and Accountability Act, a US law designed to provide privacy standards to protect patients' medical records and other health information.

You must submit your completed **HIPAA AUTHORIZATION** to your physician and the Fund Office. This form gives your physician permission to share your health information with the Fund and permission for the Fund to use this information in determining your benefit.

Employee Name		Today's date	
Social Security number		Primary phone number	
Date of birth		Email address	
Home address	City	State	Zip code

I authorize the health care provider(s) named on this form to release to the Board of Trustees of the Electrical Workers Local 369 Benefit Fund, or their designated representative, the health care information pertaining to my claim for a Disability Benefit from the Plan.

I understand that:

- ☐ The purpose for obtaining this information is to assist the Board of Trustees of the Electrical Workers Local 369 Benefit Fund in determining my eligibility for a Disability Benefit from the Plan.
- ☐ I have the right to inspect the health care information released to the Board of Trustees of the Electrical Workers Local 369 Benefit Fund or their designated representative.
- ☐ The Board of Trustees of the Electrical Workers Local Union Benefit Fund cannot further disclose the health care information it obtains without my written consent, except as provided by state or federal law.
- ☐ This consent will remain in effect until _____ (expiration date or event). However, I may revoke my consent in writing at any time except to the extent that the Board of Trustees of the Electrical Workers Local 369 Benefit Fund or their designated representative or any of the above listed providers have already taken action in reliance on this consent.

Health care providers

Name			
Phone number			
Address	City	State	Zip code
Name			
Phone number			
Address	City	State	Zip code
Name			
Phone number			

Address	City	State	Zip code
Name			
Phone number			
Address	City	State	Zip code

Type of Information That May Be Obtained (check all that are applicable):

- ☐ Medical History, Examination, Reports
- ☐ Operation Reports
- ☐ Treatment or Tests
- ☐ X-ray Reports
- ☐ Alcohol and Drug Abuse Records
- ☐ Mental Health Treatment Records
- ☐ Laboratory Reports
- ☐ Prescriptions
- ☐ Consultations
- ☐ Hospital Records, including reports
- ☐ Copies of all other health care reports

By signing this form, I affirm that, to the best of my knowledge, the information I am providing is true and accurate. I am aware that the Plan provisions are provided in the Electrical Workers Local 369 Benefit Fund Plan Document. If there is a discrepancy between the wording here and the Plan Document, the language in the Plan Document governs. I acknowledge that the Trustees reserve right to interpret, amend, modify or terminate this Plan or any of the benefits at any time.

Employee signature _____ Date _____

If you are completing this form and providing documentation as the legal representative of the employee, please complete the following.

Your Name	
Relationship	Primary phone number

Representative signature _____ Date _____

Employee Name		Today's date	
Social Security number		Primary phone number	
Date of birth		Email address	
Home address	City	State	Zip code

Physician's Certification

Please complete this form so that your patient may apply for benefits through the Electrical Workers Local 369 Benefit Fund (the Plan). We cannot approve benefits until we receive your certification.

Please fax this form to the Fund Office at 502-637-3444. Thank you for your cooperation.

Conditions as defined by the Plan:

- **Temporarily Disabled**

- **Permanently Disabled:** Physical or mental condition that, based on medical evidence, completely prevents this individual from engaging in his or her regular occupation for wage or profit.
    - The following are not eligible:
    - Due to chronic alcoholism or addiction to narcotics
    - Contracted, suffered or incurred while, or as a result of, engaging in a felonious enterprise
    - A result of an intentionally self-inflicted injury
    - A result of an injury, wound, or disability incurred while serving with the Armed Forces of the United States or state of war

- **Accidently Dismembered:** Severance of hands or feet at or above the wrist or ankle joint. Loss of sight means complete and permanent loss of sight.
    - The following are not eligible:
    - Self-inflicted injuries, suicide or attempt at suicide
    - Physical or mental sickness or infirmity, ptomaines or any kind of poisoning or bacterial infection
    - Flying for training
    - An act of war

- **Terminally Ill**

How often have you seen the patient for this problem?

☐ Weekly ☐ Monthly
☐ Bi-weekly ☐ Other please explain

What was the date you first saw the patient for this problem?

First date the employee became temporarily disabled?

Last date employee worked before becoming disabled?

What was the date you last saw the patient for this problem?

Date you will next see the patient for this problem?

Primary diagnoses

Secondary diagnoses (if applicable)

Are these conditions work-related?

Diagnostic Tests and Results

Current medications

The patient's condition is: ☐ Temporary or ☐ Permanent

If temporary, what date does the patient have your authorization to return to work?

Will he or she have restrictions upon returning to work? ☐ No ☐ Yes explain

Physician Name Today's date

Patients name

Physician specialty

Physician state physician license number

Phone number

Physician address

Based on the information presented on this form, I certify that I have examined this patient and as a result of my examination:

☐ I find the patient to be Temporarily Disabled as defined under the Electrical Workers Local 369 Benefit Fund

☐ I find the patient to be Permanently Disabled as defined under the Electrical Workers Local 369 Benefit Fund

☐ I find the patient to be Accidentally Dismembered as defined under the Electrical Workers Local 369 Benefit Fund

☐ I find the patient to be Terminally Ill as defined under the Electrical Workers Local 369 Benefit Fund

I hereby certify that the above statements, in my opinion, truly describe the patient's disability and the estimated duration thereof. Upon request, I will provide or be willing to discuss additional medical information for the processing of the above employee's temporary disability benefits.

Physician signature Date