JOURNEYMEN & APPRENTICES OF LOCAL 188
HEALTH & WELFARE FUND
c/o National Employee Benefits Administrators, Inc. (NEBA)
8657 Baypine Road, Building 5 – Suite 200, Jacksonville, FL 32256
Phone (904) 538-0100 • Fax (904) 538-0088 • Toll-Free (888) 396-5899
Email: nebajaxclaims@secure.neba-fl.com

Short Term Disability Benefit Application

Part A: To Be Completed by the Participant Claiming Benefit for Self					
1.	Employee Name		7.	Last 4 digits of SSN	###-##-
2.	Date of Birth		8.	Telephone Number	( ) -
3.	Address				
4.	Is claim for a job related injury or illness?	☐ YES ☐ NO	9.	Have you filed for Workmen's Compensation?	☐ YES ☐ NO
5.	Please provide Name, Phone Number and Claim Number for any applicable Workers Compensation carrier				
6.	Is this claim the result of an accidental injury?	☐ YES ☐ NO	**Note: If this disability is due to an accidental injury please complete and return the Fund's Accident/Injury Detail Form**		

The above answers are true and complete according to the best of my knowledge and belief. I authorize any employers, insurance company, dental / medical prepayment plan, employee welfare benefit (including the Trust), service organization, physician, practitioner or other person and hospital, including the Veteran's Administration or other Institution, to release or, obtain any medical / dental or benefit information that may be required to establish or support the validity of this claim, and further authorize said company, person or organization (including the Trust) in its discretion, to disclose to any other person, company organization so requesting any of my personal dental / medical or claim information obtained in any case study or claim review. A copy of this authorization shall be as valid as the original. I also acknowledge the subrogation right of the Plan and agree to repay any sums expended by the Plan for injury or sickness if I receive payment from another party or source. "See Summary Plan Description"

Employee Signature:_____ Date: _____

Part B: Attending Physician's Statement					
10.	Patient Name		17.	Date of Birth	
11.	Date of Illness (First Symptom), Injury (Accident) or Pregnancy (LMP)		18.	Date of First Consultation for This Condition	
12.	Date Patient Able to Return to Work (Without Restrictions)		19.	Dates of Total Disability (Estimate if Necessary)	
13.	Name of Referring Physician		20.	Name and Location of Facility (if applicable)	
14	Diagnosis or Nature of Illness or Injury				
15.	Signature of Physician	Signature:_____ Date: _____			
16.	Physician's Name, Address, Zip Code and Phone Number				

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Short Term Disability Authorization of Benefit Payment

SECTION 1 - EMPLOYEE INFORMATION					
1.	**Employee Name**		**2.**	**SSN (last 4)**	XXX-XX-
3.	**Date of Birth**		**4.**	**Telephone Number**	( ) -
5.	**Address**				
6.	**City**		**7.**	**State/Zip**	

SECTION 2 – METHOD OF PAYMENT (choose one)					
☐	**Please pay my benefits via check, mailed to the address shown above in SECTION 1**				
☐	**Please pay my benefits via direct deposit to the following bank account**				
1.	**Account type: (check one)**	☐Checking ☐ Savings	**2.**	**Bank ABA routing number:**	
3.	**Account number:**				

This authorizes the Journeymen & Apprentices of Local 188 Health & Welfare Fund (the "Fund") to send credit entries (and appropriate debit and adjustment entries), electronically or by any other commercially accepted method to my account indicated above and other accounts I identify in the future (the "Account"). This authorizes the financial institution holding the Account to post all such entries. I agree that the ACH transactions authorized herein shall comply with all applicable U.S. Law. This authorization will be in effect until the Fund receives a written termination notice from myself and has a reasonable opportunity to act on it

Employee Signature: _____ Date: _____

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Accident/Injury Details Form

Dear Participant:

Please complete this Accident/Injury Details Form and include it with the submission of your claim form for Short-Term Disability benefits.

A. Employee Information					
1.	**Employee Name:**		**4.**	**SSN (last 4 digits):**	
2.	**Date of Birth:**		**5.**	**Telephone Number:**	( ) -
3.	**Address:**				

B. Explanation of Symptoms / Condition **Please answer all of the following questions relating to the condition reported on your claim.**	
6.	When did you first experience the symptoms reported on your claim? If you are unsure, please estimate the date.
7.	Was there a specific incident that you believe caused your symptoms? For example, lifting a box, or an automobile accident?
8.	If there was a specific incident that you believe caused your symptoms, where did it occur?
9.	If there was a specific incident that you believe caused your symptoms, please describe the incident in detail below. _____ _____ _____ _____ _____

10.	If there was no specific incident that caused your symptoms, please describe how the symptoms developed. _____ _____ _____ _____ _____
11.	If there was no specific incident that caused your symptoms, please describe how the symptoms developed. _____ _____ _____ _____ _____
12.	Are your symptoms related to your employment? If yes, explain. ☐ Yes ☐ No

D. Signature

By signing below, I attest that the above answers are true and complete according to the best of my knowledge and belief.

Employee Signature:_____ Date: _____