IBEW/AECA FAMILY HEALTH

IBEW LOCAL 613 & CONTRIBUTING EMPLOYERS FAMILY HEALTH PLAN

3715 Northside Parkway • Suite 2-495 • Atlanta, Georgia 30327
1.800.922.1613 • www.nebainc.com

COVID-19 SPECIAL DISABILITY APPLICATION - CONTINUATION

This form is only to be used for certification of continued qualification for the special temporary weekly disability benefit for certain Coronavirus (COVID-19) related qualifiers. Please use the "Initial" form if you are not currently receiving benefits.

PLEASE READ: You are not entitled to payment under this benefit for any period for which you are receiving any form of paid leave from an employer. Leave under this special benefit does not provide Disability Credit of hours towards maintenance of eligibility. If you are diagnosed with COVID-19, are under the treatment of a physician and you require hospitalization or extensive care beyond self-isolation, you can apply to transition to the regular weekly disability benefit. Benefits paid under this special benefit and the regular benefit will combine towards the maximum allowed benefit period.

SECTION 1 – EMPLOYEE INFORMATION					
Employee Name	First MI Last			**SSN**	
Phone Number	( )	**Date of Birth**	/ / MM DD YYYY	**Local Union**	**IBEW 613**
Home Address	Street Address				
	City		State	Zip Code	
Last Referred Contractor		**Date Last Worked**	/ / MM DD YYYY		
Are you currently or will you be receiving any paid leave from your contractor?			☐ YES ☐ NO		
Are you receiving or has a claim been made for unemployment benefits?			☐ YES ☐ NO		

INSTRUCTIONS

Select the reason for your application for continued benefits by checking the appropriate box in Section 2. Each selection will indicate the additional information to be provided. Please note that Section 4, if required, must be completed by a licensed health care provider or, in certain instances, a public health official.

SECTION 2 – INDICATE REASON FOR SPECIALTY WEEKLY DISABILITY BENEFIT CONTINUATION (check one)	
☐	I have been diagnosed with COVID-19 and have been told that I must remain in self-isolation *Skip Section 3. Certification from doctor required in **Section 4**.*
☐	I was experiencing symptoms of COVID-19 and have sought medical care and have been told that I should not return to work *Skip Section 3. Certification from doctor required in **Section 4**.*
☐	I am under continued recommendation or order from a public health official or health care provider to cease work due to the COVID-19 related risk that my return might jeopardize the health of others *Skip Section 3. Certification from doctor or public health official required in **Section 4**.*
☐	I must remain off of work to care for a family member who has been diagnosed with COVID-19 and must remain in self-isolation *Complete **Section 3**. Certification from doctor required in **Section 4**.*

SECTION 2 OPTIONS CONTINUE ON NEXT PAGE

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☐	I must remain off of work to care for a family member who had been experiencing symptoms of COVID-19 and has been told that they must remain in isolation at this time *Complete **Section 3**. Certification from doctor required in **Section 4**.*
☐	I must remain off of work to care for a family member who is under continued recommendation or order from a public health official or health care provider to cease work due to the COVID-19 related risk that my return might jeopardize the health of others *Complete **Section 3**. Certification from doctor or public health official required in **Section 4**.*
☐	I must remain off of work to care for a son or daughter due to the continued closure of my child's school or place of care, or the continued unavailability of my child's normal child care provider *Provide requested information below. Skip Sections 3 and 4.*
	Name of child requiring your care:* _____ Name of school, place of care or normal child care provider: _____ Telephone number for school, place of care or child care provider: _____ Date that school/care expected to return to resume operation: _____ * If you are caring for multiple children impacted by COVID-19 closures, you only need to fill out information for one of those children for validation.

SECTION 3 – COMPLETE ONLY IF BENEFIT BEING REQUESTED DUE TO NEED TO CARE FOR A FAMILY MEMBER

Name of family member:		**Relation to employee:**	
Is anyone else receiving paid employer leave in order to care for this same family member?			☐ YES ☐ NO
If the family member is a child, do you certify that the child's normal child care provider (including another family member who would not need to cease work to care for the child) is unable to care for the child at this time?			☐ YES ☐ NO

SECTION 4 – CERTIFICATION FROM HEALTH CARE PROVIDER OR PUBLIC HEALTH OFFICIAL
To be completed by attending physician or public health official with appropriate jurisdiction
After completing and signing this section, physician/health official should return to the employee for submission

Patient's Name:			**Patient's Date of Birth:**		
Does the patient have a confirmed diagnosis of COVID-19?	☐ YES ☐ NO	**Have you recommended or ordered a period of self-isolation or quarantine to this patient, either due to their own health risk or the risk they would pose to others in the community, due to a diagnosis or risk of COVID-19?**			☐ YES ☐ NO
Dates of recommended period of self-isolation or quarantine:		**From:**		**Through:**	
Date patient able to return to work, school or other normal activity:					
Remarks:					
Signature:			**Date Signed:**		
Address:			**Agency** (Public Health Official Only)		

EMPLOYEE MUST SIGN ON FOLLOWING PAGE

SECTION 4 – SIGNATURE			
The above answers are true and complete according to the best of my knowledge and belief. I authorize any employers, insurance company, medical prepayment plan, employee welfare benefit (including the Fund), service organization, physician, practitioner or other person and hospital, including the Veteran's Administration or other Institution, to release or, obtain any medical 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 Fund) 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 the original. I also acknowledge the subrogation right of the Plan, and additionally agree to repay any sums expended by the Plan for injury or sickness from caused or resulting from the intentional acts or negligence of another party or source. Additionally, should I receive any payments pursuant to this statement which I am presently or may become ineligible to receive, I agree to return same.			
Signature:		**Date Signed:**	

TO ENSURE RECEIPT OF YOUR APPLICATION, WE STRONGLY RECOMMEND THAT YOU RETURN THE FORMS VIA FAX OR SECURE UPLOAD ON THE NEBA WEBSITE.

To submit via fax, please send to: 833.540.3745

To submit via secure upload, visit: https://www.nebainc.com/send-secure-file/ (instructions are given on site)

If necessary, forms can also be submitted via mail to:

National Employee Benefits Administrators, Inc.
Attention: Disability
2010 N.W. 150th Ave., Suite 100
Pembroke Pines, FL 33028

IMPORTANT NOTE REGARDING UNEMPLOYMENT BENEFITS: This special weekly disability is not available for during any period for which you are receiving an unemployment benefit.