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 - INITIAL

This form is only to be used for initial application for the special temporary weekly disability benefit for certain Coronavirus (COVID-19) related qualifiers. Continuation of benefits beyond two weeks will require reapplication (using "Continuation" application) every two weeks to certify continuing qualification.

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	

SECTION 2 – METHOD OF BENEFIT PAYMENT

Provide information on how you would like to receive your benefits (choose one)

☐ Please pay my benefits via direct deposit to the following bank account (complete the fields below)

Account type:	☐ Checking ☐ Savings	**9-Digit Bank ABA routing number:**	
Account number:			

This authorizes the IBEW Local 613 and Contributing Employers Family Health 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.

Authorized Signature:

Print Name:		**Date:**	

☐ Please pay my benefits via check, mailed to the address shown above in SECTION 1.

Please note that payment of weekly disability benefits may be delayed due to interruption of business operations or services due to COVID-19. We recommend selection of direct deposit to minimize chance of delay.

FORM CONTINUES ON NEXT PAGE

SECTION 3 – REASON FOR SPECIAL WEEKLY DISABILITY BENEFIT APPLICATION

Indicate the reason you are applying for the benefit and supply all requested information (check one):

☐ I have been diagnosed with COVID-19 by a medical professional and have been told that I must self-isolate.

Name of medical provider: ______________ Date of diagnosis: ______________

Dates of recommended self-isolation period: From: ______________ Through: ______________

☐ I am experiencing symptoms of COVID-19 and must see a medical provider for diagnosis or care.

Do you have an appointment scheduled with a medical provider? ☐ YES ☐ NO

If yes, please provide date of appointment: ______________ Date you are expected to return to work: ______________

☐ I am under a recommendation or order issued by a public health official or a health care provider to cease work because I have either been exposed to COVID-19 or I am experiencing symptoms of COVID-19 and my presence on the job would jeopardize the health of others.

Who has issued the order or recommendation: ______________

Dates of period you have been told not to work: From: ______________ Through: ______________

☐ I must take time off work to care for a family member who (check situation that applies)

- ☐ Is self-isolating because they have been diagnosed with COVID-19;
- ☐ Is experiencing symptoms of COVID-19 and must see a medical professional for diagnosis or care; or
- ☐ Is under recommendation or order by a public health official or health care provider to isolate or quarantine because the family member has been diagnosed with COVID-19 or is exhibiting symptoms of COVID-19 and the presence of the family member in the community would jeopardize the health of others.

Name of family member: ______________ Relation to employee: ______________

Dates of period you must care for family member: From: ______________ Through: ______________

☐ I must take time off work to care for my son or daughter because his/her school or place of care has been closed, or the normal child care provider of such child is unavailable, due to COVID-19.

Name of school, place of care or child care provider: ______________

Telephone number for school, place of care or child care provider: ______________

Date that school/care expected to return to resume operation: ______________

PLEASE NOTE THAT DOCUMENTATION OF QUALIFICATION FOR DISABILITY, INCLUDING WRITTEN CERTIFICATIONS BY MEDICAL PROVIDERS, MAY BE REQUESTED FROM TIME TO TIME AND CONTINUED QUALIFICATION FOR BENEFITS WILL BE DEPENDENT UPON TIMELY RECEIPT OF ALL REQUESTED INFORMATION.

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:**	

PLEASE RETURN FORM VIA FAX AT 833.540.3745, OR SECURE UPLOAD AT https://www.nebainc.com/send-secure-file/

IF NECESSARY TO MAIL: NEBA, Inc. Attn: Disability, 2010 NW 150th Ave, Suite 100, Pembroke Pines, FL 33028