Insulators and Allied Workers National Medical Fund
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Administered by:
NATIONAL EMPLOYEE BENEFITS ADMINISTRATORS, INC.
NEBA

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				