IBEW Local 716 - Electrical Medical Trust - Short Term Disability Claim

To expedite your claim review, STD claims may be submitted in person at the EMT office.
Or, you may complete the form and submit by fax to (866) 316-4794
You may also send to: Electrical Medical Trust, 8441 Gulf Freeway Ste 304, Houston, TX 77017 **Customer Service : 713-643-9300**

EMPLOYEE SECTION - PLEASE PRINT AND COMPLETE IN FULL TO PREVENT DELAY IN PROCESSING

1. EMPLOYEE NAME | 2. PLAN NUMBER | 3. EMPLOYER NAME

4. EMPLOYEE HOME MAILING ADDRESS CITY STATE ZIP

EMPLOYEE EMAIL ADDRESS

5. EMPLOYEE TELEPHONE NUMBER (_____) _____-_____

6. DATE OF BIRTH _____ /_____ /_____

7. SOCIAL SECURITY NUMBER _____ - _____ - _____

8. ☐ MALE ☐ FEMALE

9. ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ LEGALLY SEPARATED ☐ DIVORCED

10. NUMBER OF DEPENDENTS UNDER AGE 18 _____

11. IS DISABILITY DUE TO YOUR EMPLOYMENT? ☐ YES ☐ NO
IF "YES", HAVE YOU FILED A WORKERS' COMPENSATION CLAIM? ☐ YES ☐ NO

12. IS DISABILITY DUE TO AN ACCIDENT? ☐ YES ☐ NO
IF "YES", DO YOU INTEND TO FILE SUIT? ☐ YES ☐ NO

13. IF YOU ANSWERED "YES" TO QUESTION (11) AND/OR (12), PLEASE PROVIDE THE FOLLOWING
DATE OF ACCIDENT TIME PLACE
ACCIDENT DETAILS

14. DATE SYMPTOMS FIRST APPEARED _____ /_____ /_____

15. RETURN TO WORK DATE ☐ ACTUAL _____ /_____ /_____ ☐ POSSIBLE

16. ARE YOU ELIGIBLE TO RECEIVE ANY OTHER INCOME (SOCIAL SECURITY, WORKERS' COMPENSATION, STATE DISABILITY, PENSION, NO-FAULT, ASSOCIATION/INDIVIDUAL DISABILITY PLANS AND SALARY CONTINUATION AND/OR SICK LEAVE BENEFITS, ETC.)? ☐ YES ☐ NO IF "YES", ATTACH A COPY OF THE AWARD LETTER OR SUPPLY TYPE OF BENEFITS, AMOUNT, FREQUENCY, TELEPHONE NUMBER, AND IDENTIFICATION NUMBER OF SOURCE (ATTACH A SEPARATE PAPER IF NEEDED)

17. IF YOUR REQUEST FOR SHORT TERM DISABILITY IS APPROVED AND YOUR BENEFIT IS TAXABLE, PLEASE GIVE AMOUNT YOU WANT US TO WITHHOLD **PER WEEK** FOR FEDERAL INCOME TAX (MUST BE WHOLE DOLLAR AMOUNT OF AT LEAST $20 PER WEEK AND MAY NOT REDUCE BENEFIT TO LESS THAN $10). **$_____ OR _____%**
PLEASE NOTE: CERTAIN DISABILITY BENEFITS ARE CONSIDERED SUPPLEMENTAL WAGES BY THE IRS (SEE IRS PUBLICATION 15A). IF YOUR DISABILITY BENEFIT IS DETERMINED TO MEET THESE REQUIREMENTS, A MANDATORY FEDERAL INCOME TAX WITHHOLDING (25%) IS REQUIRED. IF YOUR CLAIM IS PAYABLE, EMT WILL ADVISE YOU AT TIME OF PAYMENT IF THIS MANDATORY WITHHOLDING APPLIES TO YOUR BENEFIT PAYMENTS.

18. Any person who knowingly and with intent to defraud the EMT or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

"Please Note: Your Social Security number is required for IRS tax reporting purposes. Your Social Security number will not be used or disclosed to anyone for any other purpose and will not be retained in any record other than that pertaining to the claim."

PLEASE NOTE: THE ATTACHED HIPAA AUTHORIZATION MUST BE COMPLETED

SIGNATURE OF EMPLOYEE _____ DATE _____

PHYSICIAN SECTION – PLEASE COMPLETE IN FULL AND RETURN TO EMT OFFICE TO PREVENT DELAY IN PROCESSING

1. DIAGNOSIS(ES) | 2. ICD-10 CODE(S)

3. IS PATIENT'S DISABILITY DUE TO A) EMPLOYMENT ☐ YES ☐ NO B) ACCIDENT ☐ YES ☐ NO C) PREGNANCY ☐ YES ☐ NO

4. IF DISABILITY IS DUE TO PREGNANCY, PLEASE INDICATE DATE OF DELIVERY ESTIMATED _____ /_____ /_____ (IF UNDELIVERED)
PLEASE INDICATE TYPE OF DELIVERY ☐ VAGINAL ☐ C-SECTION ☐ MULTIPLE BIRTHS ACTUAL _____ /_____ /_____

5. DATE SYMPTOMS FIRST APPEARED _____/_____/_____

6. DATE OF FIRST VISIT FOR THIS CONDITION _____ /_____ /_____

7. A) DATES OF TREATMENT FOR THIS CONDITION

7. B) DATE OF PATIENT'S NEXT APPOINTMENT _____ /_____ /_____

8. HEIGHT _____
WEIGHT _____ LBS

9. DATE PATIENT WAS TOTALLY DISABLED (UNABLE TO WORK)
FROM _____ /_____ /_____ THROUGH _____ /_____ /_____

10. IF PATIENT STILL DISABLED, GIVE DATE FOR ANTICIPATED RELEASE TO RETURN TO WORK _____ /_____ /_____

11. DATES PATIENT WAS HOSPITALIZED (IF APPLICABLE)
FROM _____ /_____ /_____ THROUGH _____ /_____ /_____

12. SURGICAL DATE(S): _____
CPT(S)/PROCEDURE(S) _____

13. A) WOULD YOU SUPPORT THE PATIENTS RETURN TO WORK ON A LIMITED BASIS? ☐ YES ☐ NO
IF "YES", PLEASE PROVIDE RESTRICTIONS AND LIMITATIONS THAT WOULD BE IN PLACE

13. B) DURATION OF ABOVE RESTRICTIONS: _____

14. A) WAS PATIENT REFERRED TO YOU BY ANOTHER PHYSICIAN? ☐ YES ☐ NO
IF "YES", PLEASE GIVE NAME AND TELEPHONE NUMBER OF PHYSICIAN

14. B) DID YOU REFER PATIENT TO ANOTHER PHYSICIAN? ☐ YES ☐ NO
IF "YES", PLEASE GIVE NAME AND TELEPHONE NUMBER OF PHYSICIAN

15. DO YOU BELIEVE THE PATIENT IS COMPETENT TO ENDORSE CHECKS AND DIRECT THE PROCEEDS THEREOF? ☐ YES ☐ NO

16. PRINTED NAME OF PHYSICIAN _____ SPECIALTY _____

PRINTED ADDRESS OF PHYSICIAN_____ TELEPHONE NUMBER (_____) _____-_____

FAX NUMBER (_____) _____-_____ EMAIL ADDRESS _____ TAX ID # _____

SIGNATURE OF PHYSICIAN _____ DATE _____

PLAN ADMINISTRATOR SECTION – PLEASE PRINT AND COMPLETE IN FULL TO PREVENT DELAY IN PROCESSING

1. EMPLOYER NAME

2. PLAN NUMBER

3. EMPLOYER ADDRESS CITY STATE ZIP

4. IF BRANCH OR AFFILIATE, PLEASE PROVIDE NAME OF PARENT COMPANY EMPLOYER SOCIAL SECURITY OR TAX ID

5. DATE EMPLOYEE TERMINATED/RESIGNED

6. EMPLOYEE NAME

7. EMPLOYEE SOCIAL SECURITY NUMBER _____ - _____ - _____

8. EMPLOYEE DATE OF BIRTH _____ /_____ /_____

9. EMPLOYEE JOB TITLE

10. DATE OF EMPLOYMENT _____ /_____ /_____

11. DATE EMPLOYEE EFFECTIVE FOR STD _____ /_____ /_____

12. EMPLOYEE INSURANCE CLASS _____

13. ACTUAL LAST DAY WORKED _____ /_____ /_____

14. NORMAL WORK SCHEDULE: MON ☐ TUES ☐ WED ☐ THURS ☐ FRI ☐ SAT ☐ SUN ☐ _____ HOURS/WEEK _____ HOURS/DAY

15. HOURS WORKED ON LAST DAY

16. REASON FOR LEAVING WORK: ☐ DISABILITY ☐ **OTHER:** _____

17. CAN THE EMPLOYEE'S JOB BE MODIFIED TO ALLOW FOR RETURN TO WORK?
☐ YES ☐ NO ☐ MAYBE, DEPENDING ON RESTRICTIONS

18. DATE EMPLOYEE RETURNED TO WORK _____ /_____ /_____ ☐ PART TIME ☐ FULL TIME

19. SALARY – PLEASE PROVIDE: ☐ HOURLY ☐ WEEKLY ☐ BI-WEEKLY ☐ SEMI-MONTHLY ☐ MONTHLY ☐ YEARLY

EMPLOYEE'S BASE SALARY (DO NOT INCLUDE BONUS , OVERTIME OR COMMISSIONS) $_____ (PLEASE CHECK FREQUENCY ABOVE)

EMPLOYEE'S TOTAL BONUS AND COMMISSIONS OVER LAST 24 MONTHS **(IF APPLICABLE)** $_____ FROM _____ /_____ /_____ TO _____ /_____ /_____

EFFECTIVE DATE OF EMPLOYEE'S LAST SALARY CHANGE: _____

IF EARNINGS DEFINITION BASES SALARY ON PRIOR YEAR W-2, PLEASE ATTACH A COPY OF THE PRIOR YEAR W-2 (IF EMPLOYED IN PRIOR YEAR) OR PROVIDE YEAR-TO-DATE SALARY: $_____ FROM _____ /_____ /_____ TO _____ /_____ /_____

20. DOES THE EMPLOYEE CONTRIBUTE TO THE COST OF THEIR SHORT TERM DISABILITY INSURANCE PREMIUM? ☐ YES ☐ NO

IF "YES", PLEASE BE SURE TO COMPLETE THE FOLLOWING ACCURATELY AND FULLY

_____**%** PAID BY EMPLOYEE, ☐ PRE TAX ☐ POST TAX

22. A) DID THIS DISABILITY ARISE OUT OF EMPLOYMENT? ☐ YES ☐ NO

B) HAS A WORKERS' COMPENSATION CLAIM BEEN FILED? ☐ YES ☐ NO

23. **JOB DESCRIPTION** – **Please fully complete the following details about the physical aspects of the claimant's job as performed in an 8 hour work day. Please also attach a description of job duties, if available.**

	NEVER	OCCASIONALLY .25 – 2.5 DAILY HRS	FREQUENTLY 2.5 – 5.5 DAILY HRS	CONTINUOUSLY 5.5 – 8 DAILY HRS		NEVER	OCCASIONALLY .25 – 2.5 DAILY HRS	FREQUENTLY 2.5 – 5.5 DAILY HRS	CONTINUOUSLY 5.5 – 8 DAILY HRS
SIT					WALK				
STAND					DRIVE				
LIFT/CARRY	INDICATE AMOUNT/FREQUENCY BELOW				REACH ABOVE				
0-10 LBS					BEND/STOOP				
10-20 LBS					USE HANDS FOR	INDICATE ACTIVITY/FREQUENCY BELOW			
20-50 LBS					PUSHING/PULLING				
50-100 LBS					FINE MANIPULATION				
OVER 100 LBS					STRESS LEVEL ☐ LOW ☐ MODERATE ☐ HIGH ☐ VERY HIGH				

24. I CERTIFY THAT I HAVE REVIEWED THE ABOVE INFORMATION AND THAT THE EMPLOYEE NAMED ABOVE HAS BEEN A FULL-TIME ACTIVE EMPLOYEE FOR WHOM PREMIUMS HAVE BEEN PAID.

AUTHORIZED EMPLOYER SIGNATURE _____ DATE _____

PRINTED NAME OF AUTHORIZED PERSON _____ TITLE _____

TELEPHONE NUMBER (_____) _____-_____ EXT_____ FAX NUMBER (_____) _____-_____ EMAIL ADDRESS _____

Authorization to Obtain Medical Records And Other Information

Send to: Electrical Medical Trust, 8441 Gulf Freeway Ste 304, Houston, TX 77017
Customer Service: 713-643-9300 FAX: 866-316-4794

I, the undersigned, AUTHORIZE any physician, medical or mental health professional, medical practitioner, hospital, clinic, healthcare or other medical or medically related facility, healthcare provider, pharmacy, pharmacy benefit manager, therapist, benefit plan administrator, business associate, insurer or reinsurer, consumer reporting agency subject to the Fair Credit Reporting Act, insurance support organization, insurance agent, employer, financial institution, Governmental Agency including The Social Security Administration, The Veteran's Administration or any other organization or person having any knowledge of The Insured or The Insured's health to give The Electrical Medical Trust ("EMT") or its employees and agents, or its authorized representatives, or third parties, any information in its possession about The Insured. This information includes, but is not limited to, medical information as to cause, treatment, diagnoses, prognoses, consultations, examinations, tests or prescriptions with respect to The Insured's physical or mental condition or treatment of The Insured. This may include (but is not limited to) HIV infection, any disorder of the immune system, including acquired immune deficiency syndrome (AIDS), mental illness or use of alcohol or drugs. This information also includes non-medical information concerning The Insured, The Insured's occupation, employment history, driving history, earnings or finances or information otherwise needed to determine policy claim benefits that may be due The Insured.

I, the undersigned, UNDERSTAND that this authorization is part of the EMT's Proof of Loss requirement and if I revoke or fail to sign this authorization or alter its content in any way, it may affect the handling of The Insured's claim, including the denial of benefits under The Insured's policy. I further authorize EMT to disclose information contained in my claim file with third parties specializing in social security disability claims.

I, the undersigned, UNDERSTAND that I have the right to revoke this authorization in writing at any time by sending a written request for revocation to EMT at 8441 Gulf Freeway Suite 304 Houston Texas 77017. I understand that a revocation is not effective to the extent that EMT has already relied on this authorization, or to the extent that the company has a legal right to contest a claim under an insurance policy or to contest the policy itself.

I, the undersigned, UNDERSTAND some states require that I be informed that: "Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act, which is a crime and subject to criminal prosecution, substantial civil penalty and the stated value of the claim for each violation."

I, the undersigned, AGREE the information obtained with this authorization may be used by EMT to determine eligibility for benefits under The Insured's plan. A photocopy of this form is as valid as the original, and I may request one.

I, the undersigned, AUTHORIZE the Social Security Administration to release information or records about _____ (The Insured) to EMT or its authorized representatives. This information is to be released in order to properly adjudicate The Insured's claim or continue The Insured's eligibility for benefits. Please release detailed earnings for up to the last ten years and/or summary record of total earnings and/or information from master benefit records regarding award, denial or continuing benefits. I declare that all answers, statements and information made or given by me, or at my direction, in connection with this claim are and have been complete and true.

_____ _____ _____

Signature of Insured (or authorized representative) Relationship Date

Name of insured _____

Address _____

Claim # _____ Policy # _____ Date of Birth _____

Fraud Warning Statements

The laws of several states require the following statements to appear on the claim form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Connecticut, Iowa, Nebraska and Oregon: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

Delaware, Indiana and Oklahoma: WARNING: Any person who knowingly, and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kansas: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals , for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud as determined by a court of law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana and Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment or a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties or denial of insurance benefits.

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefit.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Ohio: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison

Vermont: It is a crime for any person knowingly to provide material false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company, for any person knowingly to provide material false, incomplete, or misleading information concerning the sale of insurance or the status of an insurer, or for any person to misappropriate the funds of an insured or an applicant for insurance. Penalties include imprisonment, fines, and denial of insurance benefits.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.