For H&W Plan Only

IUOE Local 4 Health & Welfare Plan

PO Box 680, Medway, MA 02053 | Phone: 508-533-1400 Option 3 | Fax: 508-533-1425

DISABILITY CREDIT APPLICATION

If you cease to be eligible for Health & Welfare Plan coverage because you were disabled or collecting State Paid Medical Leave or State Paid Family Leave benefits, and as a result were unable to accumulate work hours during the calendar year, you may be credited with six hours per day (up to 30 hours per week) for each week. You must have been eligible for the Basic Benefits Plan on the date disability commences or be eligible by virtue of having purchased benefits through the Bridge Buy-In Plan; have been continuously eligible for benefits for at least 12 months prior to the onset of the disability; and must apply for the credit within 24 months of losing earned coverage.

You may not earn more than 52 weeks of disability credit in any consecutive five-year period.

APPLICATION MUST BE COMPLETED IN FULL & ALL PROOF DOCUMENTS SUBMITTED BEFORE CREDIT WILL BE CONSIDERED

Member's Social Security No:	Member's Full Name:	Date of Birth:

Member's Complete Address:

Member's Phone Number:	Member's E-Mail Address:

PLEASE CHOOSE ONE OF THE FOLLOWING FOUR DISABILITY OPTIONS BELOW/ON OTHER SIDE

1 **Total Disability**

Total Disability: An employee is considered Totally Disabled, if as a result of illness or accidental injury, the employee is unable to engage in any gainful occupation for which they are reasonably fitted by education, training, or experience. Total Disability must be verified by a Medical Provider below.

ICD10#: _____ Description: _____

Date Symptoms First Appeared or Accident Happened: _____

Patient Totally Disabled From Date: _____ To: _____

Physician's Name: _____

Physician's Signature: _____

Date Physician Signed: _____ Physician's Tax ID#: _____

Physician's Practice Address: _____

Physician's Practice Phone#: _____

Turn Over

2 **Workers' Compensation**

Proof Documents Required

- **Letter from Insurer Approving Workers' Compensation Claim**

Must include Start & End Date of Compensation

3 **State Paid Medical Leave**

Proof Documents Required

- **State Award Letter listing Member's Name & type of benefits received**

Must include Start & End Date of Compensation

***May submit private employer paid medical leave papers, if applicable.**

4 **State Paid Family Leave**

Proof Documents Required

- **State Award Letter listing Member's Name & type of benefits received**

Must include Start & End Date of Compensation

***May submit private employer paid family leave papers, if applicable.**

MEMBER AUTHORIZATION

I AUTHORIZE any physician, medical practitioner, hospital, clinic or other medically related facility, insurance or reinsurance company, or employer having information available as to diagnosis or treatment with respect to any physical or mental condition and/or treatment of me or my dependents and any other non-medical information of me or my dependents to give to the IUOE Local 4 Health & Welfare Plan or its legal representative any and all such information.

I UNDERSTAND the information obtained by use of the authorization will be used by the IUOE Local 4 Health & Welfare Plan to determine insurance and eligibility for benefits under my existing policy. Any information obtained will not be released by the IUOE Local 4 Health & Welfare Plan to any person or organization EXCEPT to reinsuring companies or other persons or organizations performing business or legal services in connection with the claim, or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request to receive a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original.

I AGREE that this Authorization shall be valid for the duration of the policy.

Member's Signature: _____

Date Signed: _____ Phone Number: _____