Eligibility Rules After Short Term Disability

For the months in which you are receiving short-term disability benefits, your coverage is continued on a "zero pay" basis. Any reported work hours that would have been used for continued eligibility during those months will be carried forward and applied to the applicable test period (s) after your short-term disability benefits end so you don't lose credit for those work hours. The 300-hour requirement for continued coverage will apply to months following the end of your short-term disability period.

Test Period	Eligibility Month
Jan/Feb/Mar	June
Feb/Mar/Apr	July
Mar/Apr/May	August
Apr/May/Jun	September
May/Jun/Jul	October
Jun/Jul/Aug	November
Jul/Aug/Sep	December
Aug/Sep/Oct	January
Sep/Oct/Nov	February
Oct/Nov/Dec	March
Nov/Dec/Jan	April
Dec/Jan/Feb	May

Contact Information

FUNDS OFFICE
419.666.4450
www.electricalfunds.org

AMERICAN HEALTH HOLDING
855.248.1858
www.americahealthholding.com

SOCIAL SECURITY
800.772.1213
www.socialsecurity.gov

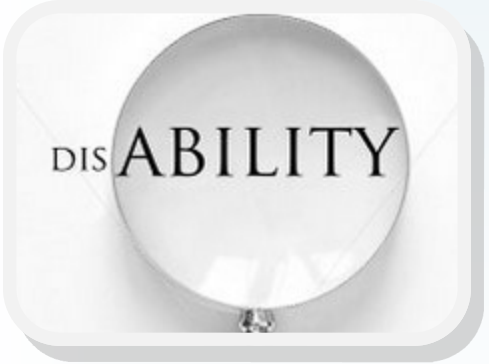
TOLEDO ELECTRICAL WELFARE FUND
P.O. Box 60408
Rossford, OH 43460

Phone: 419.666.4450
Fax: 419.666.5410
Email: disability@electricalfunds.org
Website: www.electricalfunds.org

TOLEDO ELECTRICAL WELFARE FUND

IBEW Local No. 8
NECA-OHIO/MICHIGAN CHAPTER

P.O. BOX 60408
ROSSFORD, OHIO 43460
PHONE: 419.666.4450
FAX: 419.666.5410



SHORT TERM DISABILITY AND TOTAL & PERMANENT DISABILITY

Updated June 2021

Definition of <u>Short Term Disability</u> —

A non-occupational illness or injury that prevents you temporarily from performing the essential duties of your occupation.

How to Apply for Short Term Disability

Members can contact the Funds office or log onto our website at www.electricalfunds.org to obtain the following forms required to apply for benefits:

- Disability Claim Form
- Authorization for Release of Information Form
- ACH/Direct Deposit Form (If not already on file)

Plan Design
Benefits are paid on a weekly basis, for a **<u>maximum of 26 weeks</u>**. The amount is equal to 30% of the base wage at 40 hours per week with Social Security and Medicare taxes being withheld. There are special rates for Class 26. Please call the Funds office for more information.

If your disability is due to an injury/accident, the benefit is payable immediately. If your disability is due to an illness, you have a one (1) week waiting period. The one (1) week waiting period is satisfied if you are off work sick and have a physician excuse for the period of absence.

In order to reapply for the same injury/illness and receive a new 26-week benefit period, you must return to work for at least two (2) weeks continuous weeks.

Please Keep in Mind

- The Benefit week is Monday thru Friday and applications are due by 5 p.m. Friday for the preceding week.
- Your physician will be ***required*** to complete a disability continuation form <u>every 4 to 6 weeks</u>. This form <u>must</u> be received in our office by 5 p.m. Friday for the preceding week in order to continue receiving disability payments.
- Benefits are taxable income for which tax documents will be provided. Tax levy or child support orders will affect your benefit amount.
- As of April 1, 2012, all disability benefit payments are by direct deposit. No paper checks will be issued.
- Benefits are paid every Monday and are deposited into the bank account you designate. Deposits typically post on Tuesday. If Monday is a holiday, deposits will post on Wednesday.
- If you have current active eligibility in the Plan and your disability is not work-related, you may be eligible.
- You cannot collect the ERP (Employee Retention Program) benefit and disability at the same time.
- If the disability is due in whole or in part to another person's or entity's negligence, you will be required to reimburse the Plan the short-term benefits paid to you out of any settlement or judgement proceeds you receive.

<u>Return to Work</u>

You must provide our office with a return to work slip from your physician when released back to work with no restrictions.

Total & Permanent Disability

If a short-term disability claim has been "maxed out" by reaching the 26-week maximum, weekly paid monetary benefits will stop. Eligibility in the Health & Welfare Plan will no longer be placed on hold and soon, without your return to work, you may be required to make a self-pay to maintain insurance benefits. (Please refer to Eligibility Rules found on back of this page)

At any time, if one's physician assures them that the disability will prevent them from working beyond 26 weeks, they may apply for Total and Permanent Disability. This application is voluntary.

Please keep in mind that Total and Permanent Disability, if approved, will not award a continued monetary weekly benefit. It will, however, entitle you to the Early Retiree health plan provisions and associated self-pay rate.

Members can contact the Funds Office or log onto our website at www.electricalfunds.org to obtain the Total & Permanent Disability application. You must complete and file this form in order to be considered for benefits.

<u>Other Considerations</u>

You may want to consider contacting Social Security to apply for Social Security/Disability benefits. SSDI will potentially provide a monetary benefit if they find you to be eligible.

SOCIAL SECURITY
800.772.1213
www.socialsecurity.gov

SHORT TERM DISABILITY CLAIM FORM

Toledo Electrical Welfare Fund P.O. Box 60408 Rossford, OH 43460

Telephone: 419/666-4450 **Fax**: 419/666-5410

To Be Completed By Member *For a prompt review of your claim, **ALL** of this form must be thoroughly completed by the appropriate persons.*

PLEASE COMPLETE IN FULL TO PREVENT DELAY IN BENEFITS

Full Name | Last 4 SSN | Sex M ☐ F ☐

Address | City/State | Zip

Phone No. ( ) | Date of Birth / / | Marital Status: Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed ☐

Cause of Disability: ☐ Accident** ☐ Illness ☐ Pregnancy ☐ Other _____ | Date disability began: ___/___/___ | Last date worked before disability: ___/___/___

Were you employed on date disability began? Yes ☐ No ☐ **If yes**, what is name of employer?

Is your disability work related? Yes ☐ No ☐ **If yes**, have you filed a Workers' Compensation claim? ☐ Yes ☐ No

Have you received any income from Unemployment Compensation since the date the disability began? ☐ Yes ☐ No

Nature of illness and when symptoms first appeared, or describe when, where and how accident occurred.

Is disability related to a motor vehicle accident or is another third party liable? ☐ Yes ☐ No

***Physician/clinical notes are REQUIRED and subject to review for disabilities caused due to accident*

I realize that failure to disclose other insurance coverage information or to falsify information to the TEWF is considered a fraudulent act against the Fund. A fraudulent act may result in denial of eligibility under the benefit plans.

Member Signature _____ **Date** _____

To Be Completed By The Attending Physician *The following information is required to document the patient's inability to work.*

*The member is responsible for obtaining a **complete** form without expense to TEWF. **Please complete this form and mail or fax it to TEWF using contact info listed above.***

PLEASE COMPLETE IN FULL TO PREVENT DELAY IN BENEFITS

DIAGNOSIS Written description:

ICD-10:

Pregnancy *(if applicable)* **A.** Expected delivery date: / / **B.** Actual date of delivery: / /

***Physician/clinical notes are REQUIRED for disabilities caused due to accident*

When did symptoms appear or accident happen? ___/___/___ | Date of first visit for this condition ___/___/___

Is this condition related to the patient's employment? ☐ Yes ☐ No | Date patient first recommended to stop work: ___/___/___

Did you complete a Workers' Compensation claim form for the patient regarding this disability? ☐ Yes ☐ No

Is patient still under your care for this condition? ☐ Yes ☐ No | Has patient ever had the same or similar condition? ☐ Yes ☐ No

If yes, please describe and list dates:

Describe patient's physical and/or mental limitations and restrictions (functional capacity).

How long do you expect these limitations and restrictions to cause your patient to be unable to work?

☐ DATE _____ to _____ ☐ Unable to determine, follow up in _____ weeks ☐ Permanently

(Print) Name of physician completing this form | Tax Id # or SSN | **Fax Number** | Phone Number

Address | City | State | Zip Code

Acknowledgement- I certify hat the answers I have made to the above questions are complete and true to the best of my knowledge and belief.

Physician Signature _____ **Date** _____

Toledo Electrical Welfare Fund

Authorization for Release of Information

I, _____, hereby authorize this release of information to IBEW Local Union 8 for the purpose of determining my return-to-work status.

I acknowledge that any and all information related to my case or claim may be released to IBEW Local Union 8. I further acknowledge that the TEWF is not responsible for the confidentiality of any information released under this authorization, upon release to IBEW Local Union 8. I expressly hold harmless the Toledo Electrical Welfare Fund ("TEWF") and its employees, management, and Board of Trustees for any release of information related to this authorization.

I understand that I may revoke such Authorization at any time by providing written notice of my intention to revoke such Authorization. Any information disclosed or disseminated prior to the Toledo Electrical Welfare Fund's receipt of such notice of revocation or for a reasonable administrative period thereafter shall not be affected by such notice, and no liability shall accrue as a result of such disclosure or dissemination.

_____ _____

Member Signature **Date**

_____ _____

Parent/Legal Guardian Signature **Date**

(if patient is a minor/under age 18)

_____ _____

Authorized Representative Signature **Date**

(if patient is unable to sign)

TOLEDO ELECTRICAL WELFARE FUND

Authorization for Release of Information

The following Authorization is requested by American Health Holdings, Inc. for the specific purpose of utilizing such information for Medical and/or Psychiatric Case Management for which the above-mentioned organization has been contracted. This information may be disseminated to other parties who are legally entitled to receive such information.

Signing this Authorization does not in any way waive your right to complete and total confidentiality of such information as required by the Federal Compliance and Federal Alcohol and Drug Abuse Acts.

Please sign and return one copy of the Authorization to the address shown below, the second copy should be retained for your records. Such Authorization will remain in effect for a period of one year from the date such information is received.

I _____, hereby authorize this release of Medical or Psychiatric information to American Health Holdings, Inc.

I, the undersigned, acknowledge all relevant Medical or Psychiatric information related to my case or claim may be released to the above referenced parties, legally entitled to receive same, for the purposes of case management and claims processing. I understand that all information will be treated confidentially and I may revoke such Authorization at any time.

This Authorization may be revoked by me at any time by providing written notice of my intention to revoke such Authorization. Any information, disclosure or dissemination prior to notice of revocation shall not be effected by such notice.

_____
Patient Signature & Date

_____
Parent/Legal Guardian Signature & Date
(If patient is a minor/under age 18)

_____ _____
Authorized Representative Signature & Date Relationship to Patient
(If patient is unable to sign)

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