

HEALTH PLAN BENEFITS

TIME LOSS/DISABILITY WAIVER APPLICATION

HARRISON ELECTRICAL WORKERS TRUST FUND
PMB #116
5331 S Macadam Avenue Ste 258
Portland, OR 97239
In Portland Area (503) 224-0048
All Other Locations 1-800-547-4457

PART 1: MUST BE COMPLETED BY PARTICIPANT

PARTICIPANT'S FULL LEGAL NAME: _____

LAST FOUR DIGITS OF SSN: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ DATE OF BIRTH: _____

PHONE NUMBER: (_____) _____ EMAIL: _____

EMPLOYER: _____

WAS THE CONDITION RELATED TO:

A) PARTICIPANT'S EMPLOYMENT

YES NO

B) AN ACCIDENT

YES NO

IF AN ACCIDENT:

DATE 20 AND TIME a.m. / p.m.

DESCRIPTION (HOW AND WHERE):

ARE YOU APPLYING FOR (CHECK ALL THAT APPLY): TIME LOSS BENEFIT DISABILITY WAIVER

HAVE YOU APPLIED FOR PAID LEAVE OREGON/WASHINGTON? YES NO

HAVE YOU ALREADY APPLIED FOR THE FMLA BENEFIT? YES NO

IF YOU SELECTED NO, PLEASE COMPLETE THE FMLA APPLICATION, WHICH IS ONLINE AT WWW.HARRISONBENEFITS.ORG

PARTICIPANT RELEASE SIGN BELOW*

I HEREBY AUTHORIZE ANY INSURANCE COMPANY, PREPAYMENT ORGANIZATION, EMPLOYER, HOSPITAL OR PHYSICIAN, TO RELEASE ALL INFORMATION WITH RESPECT TO MYSELF WHICH MAY HAVE A BEARING ON THE BENEFITS PAYABLE UNDER THIS OR ANY OTHER PLAN PROVIDING BENEFITS OR SERVICES. I HEREBY CERTIFY THE INFORMATION PROVIDED IS CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE.

X _____
PARTICIPANT DATE

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PART 2: TO BE COMPLETED BY THE ATTENDING MEDICAL PROVIDER

DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT):	DATE FIRST CONSULTED YOU FOR THIS CONDITION:	HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? YES <input type="checkbox"/> NO <input type="checkbox"/>
DATE PATIENT ABLE TO RETURN TO WORK:	DATES OF TOTAL DISABILITY: FROM: _____ THROUGH: _____	DATES OF PARTIAL DISABILITY: FROM: _____ THROUGH: _____
FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES: ADMITTED: _____ DISCHARGED: _____		_____
DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE: 1. _____ 2. _____ 3. _____ 4. _____		
SIGNATURE OF PHYSICIAN OR SUPPLIER: SIGNED: _____ DATE: _____	ENTER THE TAXPAYER IDENTIFYING NUMBER TO BE USED FOR 1099 REPORTING PURPOSES. YOU ARE REQUIRED UNDER AUTHORITY OF LAW TO FURNISH YOUR TAXPAYER IDENTIFYING NUMBER. _____	PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.: _____

PART 3: DIRECT DEPOSIT AUTHORIZATION: MUST BE COMPLETED BY EMPLOYEE

THE UNDERSIGNED PARTICIPANT ("PARTICIPANT") HEREBY AUTHORIZES AND DIRECTS THE ADMINISTRATIVE OFFICE FOR THE HARRISON ELECTRICAL TRUST FUND ("PLAN"), TO TRANSFER FUNDS FOR BENEFIT PAYMENTS TO WHICH PARTICIPANT MAY BE ENTITLED UNDER THE TERMS OF THE PLAN AS THEY BECOME DUE AND PAYABLE, AND DIRECTLY DEPOSIT SAID FUNDS BY ELECTRONIC TRANSFER TO THE ACCOUNT MAINTAINED BY PARTICIPANT AT THE FINANCIAL INSTITUTION IDENTIFIED BELOW. SAID FUNDS SHALL BE IN FULL PAYMENT, SATISFACTION AND DISCHARGE OF AMOUNTS DUE TO THE PARTICIPANT UNDER THE PLAN. PARTICIPANT AUTHORIZES AND DIRECTS FINANCIAL INSTITUTION TO REFUND ANY PAYMENTS TO THE PLAN TO WHICH PARTICIPANT, OR PARTICIPANT'S SUCCESSORS OR ESTATE, WOULD NOT HAVE BEEN ENTITLED UNDER THE PLAN AS A RESULT OF PARTICIPANT'S DEATH OR OTHERWISE, AND CHARGE THE SAME TO THE PARTICIPANT'S ACCOUNT DESIGNATED BELOW. PARTICIPANT AGREES ON BEHALF OF HIS OR HERSELF, ANY CO-TENANTS, HEIRS, EXECUTORS, SUCCESSORS AND ANY TRUSTEE ON THEIR TRUST (IF ANY) TO REIMBURSE THE PLAN FOR SUCH PAYMENTS.

<input type="checkbox"/> CHECKING ACCOUNT	<input type="checkbox"/> SAVINGS ACCOUNT	ABA ROUTING #: _____	ACCOUNT #: _____
DEPOSITORY NAME (BANK, CREDIT UNION, OR FINANCIAL INSTITUTION): _____		ADDRESS:	CITY: _____ STATE: _____ ZIP: _____

IF THE BANK IDENTIFIED ABOVE IS A FINANCIAL INSTITUTION LOCATED OUTSIDE OF THE UNITED STATES OR THE FUNDS DEPOSITED INTO THE BANK ACCOUNT IDENTIFIED ABOVE WILL BE FORWARDED TO, CREDITED OR OTHERWISE HANDLED BY A FINANCIAL INSTITUTION LOCATED OUTSIDE OF THE UNITED STATES, I WILL IMMEDIATELY NOTIFY THE TRUST OFFICE. THIS AUTHORITY IS TO REMAIN IN FULL FORCE AND EFFECT UNTIL THE HARRISON ELECTRICAL WORKERS TRUST FUND HAS RECEIVED WRITTEN NOTIFICATION FROM ME OF ITS TERMINATION IN SUCH TIME AND IN SUCH MANNER AS TO AFFORD THE HARRISON ELECTRICAL TRUST FUND AND THE DEPOSITORY A REASONABLE OPPORTUNITY TO ACT UPON IT. I ACKNOWLEDGE THAT THE ORIGINATION OF ACH TRANSACTIONS TO MY ACCOUNT MUST COMPLY WITH THE PROVISIONS OF U.S. LAW.

X _____
PARTICIPANT DATE

HOW TO REQUEST BENEFITS

THIS FORM IS TO BE COMPLETED BY THE PARTICIPANT AND THE ATTENDING MEDICAL PROVIDER:

- 1) PARTICIPANT COMPLETES **PART 1** - THE PATIENT INFORMATION SECTION
- 2) ATTENDING MEDICAL PROVIDER COMPLETES **PART 2** - THE “ATTENDING MEDICAL PROVIDER” SECTION
- 3) PARTICIPANT COMPLETES **PART 3** IF THEY WISH TO RECEIVE WEEKLY TIME LOSS BENEFITS VIA DIRECT DEPOSIT
- 4) PARTICIPANT MUST RETURN THE COMPLETED APPLICATION TO THE BENEFIT OFFICE USING YOUR PREFERRED METHOD BELOW:
 - LOGIN TO WWW.HARRISONBENEFITS.ORG, CLICK ON “DOCUMENTS TO SUBMIT”, THEN “TIME LOSS/DISABILITY” AND UPLOAD THE COMPLETED FORM
 - MAIL TO THE TRUST ADMINISTRATIVE OFFICE:
HARRISON ELECTRICAL WORKERS TRUST
PMB #116
5331 S MACADAM AVE STE 258
PORTLAND, OR 97239
 - FAX THE COMPLETED FORM TO THE BENEFIT OFFICE AT (503) 228-0149