IBEW LOCAL 351 WELFARE FUND
Application for Temporary Disability Benefits

PART I – To Be Completed by Employee

Name ________________________________ Soc. Sec. # ________________________

Street Address ____

City, State, Zip ____

Telephone # _______________________

Date Last Employed __________ Last Employer ________________________________

Were you immediately hospitalized for this condition? Yes ____ No ____

If Yes, dates of hospitalization. Admit Date __________ Release Date _____________

If an Accident: Date _______________ and Time _______________ am pm

Description of How & Where ____

___________________________________ ____________________
Signature of Employee Date

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Part II – To Be Completed by Physician

Nature of Illness or Injury ____

Date of First Treatment ___________________

Date of Most Recent Treatment ____________________

This patient has been continuously disabled (unable to work) starting: _______________
(date)

When should patient be able to return to work? ___________________
(Need estimated date)

Physician's Name: ____
(please print)

Physician's
Address: ____

Physician's Phone # ___________________ Fax #__________________

_____________________________________ ____________________
Physician's Signature Date

Part III – To Be Completed By Employee

The Internal Revenue Service requires that Temporary Disability Income payments made to you be reported to them as they will be treated as a part of your taxable income. As a result, these payments are subject to F.I.C.A. Taxes, Federal Income Taxes and New Jersey State Income Taxes. The appropriate deduction will automatically be made from your payments for FICA and New Jersey State Income Taxes. If you would like to have Federal Income Tax withheld from your payments, you may request withholding by making this election below:

Please complete this election form by selecting either Option A or Option B below. **Disability income payments will not start until this section is completed.**

Option A _____ I do not want to have Federal Income Tax withheld from Temporary Disability Income payments made to me.

Option B _____ I elect to have $_____ withheld for Federal Income Taxes from each Temporary Disability payment made to me.

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Please return this completed form to:

Linda Lawson
I.E. Shaffer & Co.
PO Box 1028
Trenton NJ 08628

Phone # (800) 792-3666 ext. 6130
FAX # (609) 883-7566