

SOUTH JERSEY ELECTRICAL WORKERS TEMPORARY DISABILITY BENEFIT FUND
c/o I. E. Shaffer & Co.
PO Box 1028, Trenton, NJ 08628-0230

This form should be completed by the Employee and Physician immediately after the commencement of disability and sent to the Employer for benefits under the New Jersey Temporary Disability Benefits Law.

WARNING

INSURANCE FRAUD IS PUNISHABLE UNDER NEW JERSEY LAW BY FINE OR IMPRISONMENT. INDIVIDUALS SUBMITTING FALSE OR MISLEADING INFORMATION WILL BE PROSECUTED TO THE FULLEST EXTENT OF THE LAW AND WILL BE SUSPENDED FROM ELIGIBILITY IMMEDIATELY.

EMPLOYEE'S STATEMENT

Member of IBEW Local Union # _____ Social Security # _____

Name of Employee _____ Date of Birth _____

Street Address _____

City, State, Zip _____ Telephone (____) _____

Date Accident Occurred or Sickness Began _____ Date Last Worked _____

Nature of Sickness or Injury _____

Were You Injured in the Course of Employment? _____

First Treated On _____ Where? _____

Dates of Hospitalization _____ Name of Hospital _____

On What Date Did You or Do You Expect To Resume Work? _____

Certification - I certify that I am not currently eligible for temporary disability benefits under the New Jersey Electrical Workers Temporary Disability Benefit Plan or any other private temporary disability benefit plan other than the South Jersey Electrical Workers Temporary Disability Benefit Plan. I authorize my physician to furnish all relevant medical information regarding my disability to the Plan Administrator, I. E. Shaffer & Co., and to Barbara A. Marrocoli, MD, Medical Director of the Medical Center at Princeton – Corporate Health Services.

Date _____ Signature _____

EMPLOYER'S STATEMENT

Is the Above Information Provided By the Employee Correct to the Best of Your Knowledge? _____

Please Note Any Errors _____

Employee's	Date Employee	Date Employee
Date of Hire _____	Last Worked _____	Notified You of Disability _____

Is Disability Result of an Occupational Disease or Occupational Injury? _____

Employee's Gross Earnings Received for Last 8 Weeks Immediately Preceding Week of Disability:

1. \$ _____	2. \$ _____	3. \$ _____	4. \$ _____
5. \$ _____	6. \$ _____	7. \$ _____	8. \$ _____

IBEW Local Union # Jurisdiction Where Employed at Time Disability Commenced _____

Employer _____ Private Plan # _____

Street Address _____

City, State, Zip _____ Telephone (____) _____

Date _____ Signature _____

PHYSICIAN'S STATEMENT

Patient's Name _____ Age _____

Nature of Sickness or Injury _____

Did This Sickness or Injury Arise Out of Patient's Employment? _____

If Yes, Explain _____

Is This Disability Due to Pregnancy? _____

Nature of Surgical or Obstetrical Procedure, If Any (Describe Fully) _____

Date Performed _____

Give Dates of Treatment

Office _____

Home _____

Hospital _____

The Patient Has Been Continuously Disabled (unable to work) From _____ Through _____

If Still Disabled, When Should Patient Be Able To Return To Work? _____

Restrictions: _____

Remarks: _____

Name of Physician _____ Telephone (_____) _____

Street Address _____

City, State, Zip _____

Date _____

Physician's
Signature _____