NEW JERSEY ELECTRICAL WORKERS TEMPORARY DISABILITY BENEFIT FUND

c/o I. E. Shaffer & Co.
PO Box 1028, West Trenton, NJ 08628 ♦ 1-800-792-3666 ♦ 1-609-530-1331 (fax)

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 South Jersey Electrical Workers Temporary Disability Benefit Plan or any other private temporary disability benefit plan other than the New 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.

Date _____ Signature _____

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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 of Hire _____ Date Employee Last Worked _____ Date Employee 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. $_____ Dates_____ 2. $_____ Dates_____ 3. $_____ Dates_____
4. $_____ Dates_____ 5. $_____ Dates_____ 6. $_____ Dates_____
7. $_____ Dates_____ 8. $_____ Dates_____

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

Employer _____Tax ID_____ 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 _____

New Jersey Electrical Workers
Temporary Disability Benefit Fund

FEDERAL INCOME TAX WITHHOLDING ELECTION STATEMENT

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. and Federal Income Taxes. The appropriate deduction will automatically be made from your payments for F.I.C.A. 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.

WITHHOLDING CERTIFICATE

A. _____I do not want to have Federal Income Tax withheld from my payment.

B. I elect to have $_____withheld for Federal Income Tax from my payment.

Your Name _____ Soc Sec # _____

Signature _____ Date _____

*****THIS ELECTION FORM MUST BE RETURNED WITH YOUR DISABILITY FORM *****