Michigan Electrical Employees' Health Plan

6011 W. St. Joseph • Suite 401 • Lansing, MI 48917
(517) 323-9250 • FAX #5173231093 • (800) 323-8943

APPLICATION FOR ACCIDENT AND SICKNESS WEEKLY DISABILITY BENEFITS

TO BE COMPLETED IN FULL BY MEMBER

NAME OF MEMBER ______________________ SOCIAL SECURITY # ______________

HOME ADDRESS ______________________ CITY __________ STATE ______ ZIP ______

PHONE # (____)______________ BIRTH DATE ______________ LOCAL # ______________

NAME OF YOUR PRESENT OR LAST EMPLOYER ______________________ PHONE # ______________

EMPLOYMENT ADDRESS ______________________ CITY __________ STATE ______ ZIP ______

CURRENT OR LAST HOURLY WAGE AMOUNT: $______________

COMPLETE FOR ACCIDENT/INJURY		COMPLETE FOR ILLNESS/SICKNESS
Date accident/injury occurred ______________		Please indicate symptoms present or reasons for seeking treatment
Date first treated ______________		______________
Where did it occur ______________		______________
Please give specific description of how it occurred ______________	OR	______________
______________		Date symptoms began ______________
______________		Date first treated ______________
Was accident / injury caused by your employment? Yes [ ] No [ ]		Was illness / sickness caused by your employment? Yes [ ] No [ ]
Have you, or do you intend to file this claim with workers' comp? Yes [ ] No [ ] Date filed ______________		Have you, or do you intend to file this claim with workers' comp? Yes [ ] No [ ] Date filed ______________

On what date did you last work? ______________

Have you resumed work? Yes [ ] No [ ] if yes, what date? ______________

ADDITIONAL REMARKS: ____

____

Are you receiving or have you received any type of income such as unemployment, workers' compensation, regular or disability pension, social security, etc. Yes [ ] No [ ]

IF YES; TYPE OF INCOME ______________
DATE ELIGIBLE FOR INCOME ______________
DATE INCOME STOPPED ______________

(Please refer to your benefit book where it indicates that your Disability Benefit is taxable income.)

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct, and complete. I hereby authorize any physician or any hospital to furnish and disclose all known facts concerning this disability. I will reimburse the Health Plan for any overpayment made to me or on my behalf due to an error on this form.

Member Signature ______________________ **Date** ______________

PHYSICIAN MUST COMPLETE THE REVERSE SIDE TO CERTIFY YOUR DISABILITY.

YOU MUST BE EXAMINED BY A PHYSICIAN AND CERTIFIED AT LEAST EVERY 6 - 8 WEEKS.

TO BE COMPLETED IN FULL BY ATTENDING PHYSICIAN

PATIENT'S NAME ______________________________ BIRTH DATE ______________

Diagnosis and Concurrent Conditions ______________________________

____

ICD-9-CM* code(s) for above ______________________________

IS CONDITION DUE TO PATIENT'S EMPLOYMENT? YES [ ] NO [ ]

Is condition due to accident / injury? YES [ ] NO [ ] Date of accident ______________

Is condition due to illness? YES [ ] NO [ ] Date illness began ______________

Date patient first consulted you for this condition ______________________________

Hospital confinement dates ______________________________

Surgery Dates ______________________________

Surgical procedures ______________________________

Date of last examination ______________________________

Patient has been continuously disabled from **(first day unable to work)** ______________

PLEASE INDICATE:

Approximate date patient will be able to return to work ______________________________

OR

Exact date patient will be able to return to work ______________________________

Is patient still under your care for this condition? YES [ ] NO [ ]

If "yes", give date of next scheduled appointment ______________________________

If "yes", please indicate any work restrictions the patient has at this time ______________

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If "no", give date your services terminated ______________________________

Additional Remarks ______________________________

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Date ______________ Physician's Signature ______________________________

Physician's Name (Printed) ______________________________

Address ______________________________

City ______________________________

Telephone # (____)______________________________

Physician's Tax ID # ______________________________

*ICD-9-CM = International Classification of Diseases

9/00