NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN		SEND TO: Email: <u>weeklyincome@neibenefits.org</u>
SPECIAL 14-DAY WEEKLY INCOME BENEFIT F (COVID-19 QUARANTINE)	ORM	(610) 557-4556 (fax) ational Elevator Industry Health Benefit Plan PO Box 476
Instructions: Complete "PLAN MEMBER" Section	n Only.	Newtown Square, PA 19073-0476
TO BE COMPLETED BY MEMBER		
Jame Last Four of Social Security No		
Street	Birth Date	Local Union No
City State	Zip Code	Phone
Employer Name	L	ast day worked
Employer Contact	Employ	ver Phone Number
Check the appropriate box:		
 My Employer directed me to Self-Quarantine on account of Coronavirus Disease 2019 (COVID-19), OR My Employer did not direct me to Self-Quarantine, but I believe I should Self-Quarantine because I have been exposed to COVID-19 or have symptoms of COVID-19 (subjective or measured fever, cough, or difficulty breathing). 		
Direct Deposit Election □ Yes □ No CHECKING ACCOUNT DEPOSITS ONLY If direct deposit is elected, A BLANK PERSONAL CHECK (MARKED "VOID") MUST ACCOMPANY THIS FORM.		
Account Number	_ Banking Routing Nu	nber
Bank Name	Street	
City State	Zip Code _	Phone
I request voluntary Federal Withholding 🗆 Yes 🛛 No 🛛 If "Yes", indicate amount to be withheld from weekly benefit. \$		
I am the payee under the above Social Security Number and I hereby request that until further notice from me is filed with the Claims Administrator, all payments be directly deposited in my account at the Bank designated above. I authorize the Bank designated to debit my account and to refund any overpayments to the National Elevator Industry Health Benefit Plan.		
I agree to reimburse the Health Benefit Plan to the extent of any overpayment which is in excess of the amounts payable under provisions of the Plan.		
ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION, WITH INTENT TO INJURE, DEFRAUD OR DECEIVE, MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND SUBJECT TO LOSS OF HEALTH BENEFIT PLAN COVERAGE.		
I certify that the statements hereon are complete and accurate to the best of my knowledge. A photocopy of this authorization shall be considered as effective and valid as the original.		
Signature of Plan Member		Date
IMPORTANT: By submitting this form, you are ONLY applying for Special 14-Day Weekly Income Benefits the Plan provides eligible Active Members who <u>Self-Quarantine on account of COVID-19</u> . If you wish to apply for Weekly Income Benefits on account of Illness or Injury you must submit the applicable Weekly Income Claim Form which must also be filled out by your Physician and Employer. These forms are available online at <u>www.neibenefits.org/members/health-plan/</u>		
TO BE COMPLETED BY THE BENEFITS OFFICE		
Employer NameAddress		
Employee Self-Quarantine Confirmed YES NO		
If "Yes" Date		
If "No" explanation:		
Reviewed by Date		