WORKERS' COMPENSATION CREDITED HOURS APPLICATION
ACTIVE HEALTH PLAN

SOUTHERN CALIFORNIA IBEW-NECA HEALTH TRUST FUND

100 Corson Street, Suite 200, Pasadena, CA 91103

Mailing Address: P.O. Box 6652, Pasadena, CA 91109

(323) 221-5861 or (800) 824-6935 (Nationwide) Fax No.: (323) 726-3520 website: www.scibew-neca.org

PLEASE COMPLETE FORM TO APPLY FOR WORKERS' COMPENSATION CREDITED HOURS

PART 1: PARTICIPANT INFORMATION

FIRST NAME	MIDDLE INITAL	LAST NAME	SOCIAL SECURITY NUMBER				–			–				
STREET ADDRESS – **DO NOT USE P.O. BOX**	APT #:	CITY	STATE	ZIP CODE										

DATE OF BIRTH:	TELEPHONE NUMBER: ( )	GENDER: ☐ MALE ☐ FEMALE

PART 2: GENERAL INFORMATION REGARDING WORKERS' COMPENSTATION CLAIM

DATE OF ACCIDENT:	LAST MONTH OF HEALTH PLAN ELIGIBILITY:
EMPLOYER'S NAME, ADDRESS AND PHONE NUMBER:	NAME OF WORKERS' COMPENSATION INSURANCE CARRIER, ADDRESS AND PHONE NUMBER:

WORKERS' COMPENSATION – CREDITED HOURS ELIGIBILITY REQUIREMENTS

ELIGIBILITY REQUIREMENTS:

1. You must have been eligible for Southern California IBEW-NECA Health Plan ("Health Plan") Plan benefits in the month in which the occupational injury occurred and had contributions paid to the Health Plan on your behalf by an Employer.
2. You must provide written notice to the Administrative Trust Funds Office within 30 days from the date your eligibility ends.
3. You must provide proof of disability and the time period of disability (i.e. Workers' Compensation Award Letter, Workers' Compensation benefit paystubs for the time period of the disability).

BENEFITS:

1. Maximum of 1,040 hours (40 hours/week; 26 weeks x 40 hours = 1,040 hours)
2. You will be given 40 hours of work credit for each week of approved Workers' Compensation temporary disability benefits, up to the maximum benefit of 26 weeks/1,040 hours. NOTE: The hours credited are Health hours only.

IMPORTANT: You must return completed application with proof that you are receiving Workers' Compensation benefits to the Administrative Trust Funds Office.

RETURN TO: Southern California IBEW-NECA Admin Corp
Attn: Health Benefits Department
P.O. Box 6652
Pasadena, CA 91109

PART 4: PARTICIPANT'S SIGNATURE REQUIRED

PARTICIPANT'S SIGNATURE	PRINTED NAME	DATE SIGNED

FOR OFFICE USE ONLY

LAST MONTH OF COVERAGE	EMPLOYER DELINQUENT	DOCUMENTS RECEIVED	INITIALS AND DATE PROCESSED
	☐ N/A ☐ MONTH(S):_______	PROOF OF WC BENEFITS: FROM __________ TO _________	