NATIONAL ELEVATOR INDUSTRY
BENEFIT PLANS

19 CAMPUS BLVD., SUITE 200, NEWTOWN SQUARE, PA 19073-3288
TOLL FREE 1-800-252-4611 / FAX 610-557-4555
WWW.NEIBENEFITS.ORG

REIMBURSEMENT AGREEMENT / WORKERS COMPENSATION CLAIMS ONLY

Name: _____ Member ID: _____

Date of Injury / Illness: _____

Description of Injury / Illness: _____

Has a Workers Compensation Claim been filed? YES NO

If no, please explain: _____

Has your Workers Compensation Carrier accepted liability on your claim? YES NO

If your Workers Compensation Claim was denied, have you filed an appeal? YES NO

As a covered member under the National Elevator Industry Health Benefit Plan ("Plan"), I acknowledge receipt of payment of expenses incurred as a result of a work related injury/illness as described above.

I hereby acknowledge the Subrogation provisions of the Plan's Summary Plan Description. In accordance with Plan provisions, I agree to reimburse, in full, the National Elevator Industry Health Benefit Plan to the extent of any recovery for said expenses made by my Workers Compensation Carrier or as a result of any legal action or settlement or otherwise.

_____ _____
(Signature of Employee) (Date)

ACTION CANNOT BE TAKEN ON YOUR CLAIM(S) UNTIL ALL OF THE BELOW LISTED INFORMATION IS PROVIDED

1. Name of your Workers Compensation Carrier: _____ Claim Number: _____
2. Workers Compensation Carrier Address: _____
3. Workers Compensation Carrier Telephone Number: _____
4. If your Workers Compensation Carrier denied your claim, or your claim is currently under review, please attach a copy of their determination.
5. If you have filed an appeal with your Workers Compensation Carrier and you have retained an attorney to assist you with your appeal, please provide the attorney's name, address, and telephone number. If you have not retained an attorney to assist you with your appeal, please indicate the same.

Please return this form with the supporting documents to the address listed above. Should you have any questions, please contact our Member Services Department at 1-800-252-4611.

PLEASE INCLUDE A COPY OF YOUR WORKERS COMPENSATION CARRIER'S DETERMINATION
COMPLETION OF THIS FORM DOES NOT GUARANTEE COVERAGE