

NATIONAL ELEVATOR INDUSTRY  
HEALTH BENEFIT PLAN  
SPECIAL 14-DAY WEEKLY INCOME BENEFIT FORM  
(COVID-19 QUARANTINE)

Instructions: Complete "PLAN MEMBER" Section Only.

SEND TO:  
Email: [weeklyincome@neibenefits.org](mailto:weeklyincome@neibenefits.org)  
(610) 557-4556 (fax)  
National Elevator Industry Health Benefit Plan  
PO Box 476  
Newtown Square, PA 19073-0476

TO BE COMPLETED BY MEMBER

Name \_\_\_\_\_ Last Four of Social Security No. \_\_\_\_\_  
Street \_\_\_\_\_ Birth Date \_\_\_\_\_ Local Union No. \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Employer Name \_\_\_\_\_ Last day worked \_\_\_\_\_  
Employer Contact \_\_\_\_\_ Employer 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 Number \_\_\_\_\_

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 **Self-Quarantine on account of COVID-19**. 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 [www.neibenefits.org/members/health-plan/](http://www.neibenefits.org/members/health-plan/)

TO BE COMPLETED BY THE BENEFITS OFFICE

Employer Name \_\_\_\_\_ EIN \_\_\_\_\_

Address \_\_\_\_\_

Employee Self-Quarantine Confirmed  YES  NO

If "Yes" Date \_\_\_\_\_

If "No" explanation: \_\_\_\_\_

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_