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
(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/

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 _____