NATIONAL ELEVATOR INDUSTRY

BENEFIT PLANS

19 CAMPUS BLVD., SUITE 200, NEWTOWN SQUARE, PA 19073-3288

REIMBURSEMENT AGREEMENT / WORKERS COMPENSATION CLAIMS ONLY

Name: ____ Plan Member ID Number: ______________________________

Date of Injury / Illness: ____________________________________

Description of Injury / Illness: ____

Have you filed a claim with your Workers Compensation carrier related the above described injury/illness? YES NO

If no, please explain: ____

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

Has your Workers Compensation Carrier authorized and paid any related medical treatment? YES NO

Have you received any related disability benefits from your Workers Compensation Carrier? YES NO

Have you received any compensation by way of settlement or otherwise from your Workers Compensation Carrier? YES NO

If your Workers Compensation Claim has been 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 the 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 <u>ALL</u> OF THE BELOW LISTED INFORMATION IS PROVIDED

1. Name of your Workers Compensation Carrier: ____
2. Claim Number: ______________________________________ Phone Number: ____
3. Workers Compensation Carrier Address: ____
4. If your Workers Compensation Carrier has denied your claim, 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 following:

   Attorney Name: ____ Phone: Number: _____________________

You may return this form with the supporting documents to the address listed above, fax to 610-557-4541, or email to weeklyincome@neibenefits.org

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