PLUMBERS & PIPE FITTERS LOCAL #354 WELFARE FUND

c/o BEACON ADMINISTRATORS & CONSULTANT'S INC.
6500 Brooktree Road
Wexford, PA 15090

Phone: (844) 746-9676 Fax: (724) 799-2284
Email: 354benefits@beaconadmin.com

Instructions for Using Form:
1. Please Print All Information Clearly
2. Part A. Must Be Completed By Insured
3. Part B. Must Be Completed By Physician

Used for Income Lost Benefits Only

Name & Address of Employer:

Date of Last Day Worked :

PART A — TO BE COMPLETED BY INSURED (PATIENT)

Name Last	First	Middle	Date of Birth	Soc Sec No.

Address Street	City	State	Zip	Telephone No.

Name of Union and No.

Nature of Disability:

(check one) ILLNESS WORK INJURY OFF JOB INJURY PREGNANCY *APPROX DATE OF CONCEPTION:*

IF INJURY, BRIEFLY DESCRIBE NATURE OF ACCIDENT:

PART B — ATTENDING PHYSICIAN'S REPORT

DATE OF INJURY OR BEGINNING OF ILLNESS

DATES OF DISABILITY: FROM TO

IF PATIENT IS NO LONGER DISABLED, DATE OF RELEASE TO RETURN TO WORK

IF STILL DISABLED, DATE OF NEXT SCHEDULED APPOINTMENT

IF STILL DIABLED, DATE ESTIMATED TO RETURN TO WORK

DOCTOR' S NAME – ADDRESS AND TELEPHONE NUMBER

DIAGNOSIS:

I DO NOT HAVE SUFFICIENT INFORMATION TO VERIFY THE STATEMENTS MADE BY INSURED

PART A IS CORRECT EXCEPT AS NOTED IN MY REMARKS

Remarks

DATE:

PHYSICIAN'S SIGNATURE

I AUTHORIZED THE PHYSICIAN'S OFFICE TO RELEASE ANY INFORMATION REQUIRED IN COMPLETING THIS FORM

SIGNATURE OF INSURED

DATE:

REIMBURSEMENT AGREEMENT

This letter is to advise you that the Plan will pursue its reimbursement and subrogation rights when benefits are paid due to accidental injury for which another party may be liable. The Plan is not interested in depriving you of any rights you may have against a third party and is prepared to cooperate with you and any attorney you may retain in enforcing your claim. Please sign the below Agreement acknowledging that you agree to cooperate with the Plan in providing the information necessary to protect the Plan's right and agree to reimburse the Plan if you have a successful third party action

I, _____, residing at
(name)

_____

_____
(address)

and covered under the Plan for Medical benefits incurred as a result of injuries suffered on

_____, by me or my dependent,_____
(date)

In accordance with the subrogation and reimbursement provision of the Plan, the undersigned hereby agrees to reimburse and pay promptly to the Plan an amount not exceeding the aggregate amount of benefits paid or to be paid to me or on my behalf under said Plan for charges incurred as a result of injury or disease out of any recovery by settlement, judgment or otherwise from such person or organization or such person's or organization's insurance carrier. The undersigned further agrees to execute instruments and papers, furnish information and assistance and other necessary and related action as the Fund may require to facilitate its rights of subrogation and reimbursement under the Plan.

I further understand that failure to permit subrogation or to reimburse the Plan in accordance with the terms of this Plan and this letter may result in the Fund setting off the amounts owed pursuant to its subrogation right or right of reimbursement against future claims made by me or my dependents.

_____
(Signature of insured)

WORKERS COMPENSATION SETTLEMENT/DISABILTY REFUND STATEMENT

Parts I &II must be completed in full.

PART I:

Participants Name: _____

Address: _____

_____

Social Security Number: _____

Have you applied for Workers' Compensation for your injury? Yes ☐ No ☐

Are you receiving Workers' Compensation for your injury? Yes ☐ No ☐

IF WORKERS' COMPENSATION WAS DENIED, DENIAL MUST BE ATTACHED.

_____

PART II:

I understand that should I receive Workers' Compensation Benefits for lost work or for Medical Benefits, I agree to refund to the Plumbers & Pipefitters Local #354 Health & Welfare Fund any monies that I have received as a result of short-term disability or other Welfare Benefits paid by the Fund.

Date: _____ Signature: _____

SIGNATURE MUST BE NOTORIZED BEFORE RETURNING TO THE FUND OFFICE

Signed & Subscribed before me on this _____ day of_____, 20_____

_____

Signature of Notary