



Professional Benefit Administrators, Inc.

INSTRUCTIONS FOR COMPLETING THE CLAIM FORM

- 1. Part A must be completed by the employee.
2. Part B must be completed by your physician.
3. Part C must be completed by IBEW Local No. 150.
4. Return the completed form to the IBEW Local No. 150 Benefit Office.

DISABILITY CLAIM FORM

Send all claims to: Professional Benefit Administrators, Inc. P. O. Box 4687 Oak Brook, IL 60522-4687 800-435-5694 Fax: 630-286-4611

Part A - Employee Information

Form containing employee information: Employer Name (IBEW Local No. 150 Welfare Fund), Employee name, Date of birth, Social Security #, Home Address, Phone, Sex, Marital Status, Claim is for (Sickness/Accident), and Certification & Authorization to Release Information.

Part B - Attending Physician Statement

Form containing physician statement: Date of illness, Date first consulted, Has patient ever had same or similar symptoms?, Date patient able to return to work, Date of total disability, Date of partial disability, Diagnosis of sickness or injury, Date of services, and Physician Signature/Address.

Part C - Employer's Certification

Form containing employer's certification: Employee's Full Name, Effective Date of Coverage, Date Employed, Date Terminated, Last Date Worked, Date Returned, Earnings, Occupation (ELECTRICIAN), Employee's work classification, and Company Name (IBEW Local No. 150).

