READ THIS BEFORE PROCEEDING

IMPORTANT INFORMATION

1. **Please review ALL the eligibility requirements and the required documentation for the benefit applying.**

2. **DOCTOR'S CERTIFICATION: The attached doctors' certification must be submitted with your Application for both work and non-work-related injury/illness claims.**

3. **Please do not send in test results, patient history, pictures, etc. They are not necessary and will not be considered in determining your eligibility.**

4. **Please submit the application and doctor's certification together. You can submit as follows:**

    - **Mail: IBEW 1245 c/o IWF, 30 Orange Tree Circle, Vacaville, CA 95687.**
    - **Fax: (707) 452-2720**
    - **Email: IWF@ibew1245.com - for your security we suggest you email the documents encrypted. NO SCREEN SHOTS. The email must be a legible PDF document.**

5. **CLAIMS(APPLICATIONS): Claims can take up to 45-days to process. Claims do not typically take that long if proper documentation is submitted.**

    - **You will be notified in writing via USPS of the decision.**
    - **If you are concerned if your application has been received:**
        - **Mail: send with some sort of tracking (not required).**
        - **Fax: you should get a confirmation that your fax was sent "Successful"**
        - **Email: You will receive an automatic reply that your email has been received.**
    - **DO NOT call/email/text to check the status of your claim, unless 45-days have passed, and you have not received a letter in the mail.**

Questions other than claim status, please call/text 707-452-2720 or email IWF@ibew1245.com

TO: MEMBERS OF OUTSIDE LINE UNIT 4911 OF IBEW LOCAL 1245

The following is a basic summary of the basic provisions of The IBEW Local 1245 Injured Workers Plan. The Plan is designed to provide basic disability and death benefits in the event you are injured (and are unable to work) or die due to a work-related injury.

SUMMARY OF THE IBEW LOCAL 1245 INJURED WORKERS PLAN

A. Employee Eligibility for Coverage under the Plan

You will become initially eligible on the first day of the benefit month, corresponding to the eligibility month in which you first accumulate at least 125 credited hours of employment for which an employer is required to make a contribution to the injured workers fund on your behalf. Once you have met the initial eligibility rules, you will remain eligible for coverage for each month in which you have contributions made for at least 100 hours of work (performed in the prior month) or 450 hours of work (performed in the six (6) months prior).

B. Eligibility for Disability Benefits

1) You must be covered under the Plan on the date your disability begins; and,

2) Your disability must begin and you must see a doctor about the disability within 15 days after the last day you worked for an Employer.

C. Benefits

To be eligible for **Work Related Disability Benefits,** you must meet the following requirements:

1. You must be totally disabled (be completely unable to perform each and every duty of your occupation or employment) as a result of an occupational bodily injury or sickness, which is related to you performing work with an employer signatory to the California Outside Line Construction Agreement; and

2. You must be covered under the Plan on the date your disability begins; and

3. Your disability must begin and you must see a doctor about the disability within fifteen (15) days after the last day you worked for an Employer. You must provide a doctor’s certification to the Plan stating that you are totally disabled for at least ten (10) days. The initial doctor’s certification must include 1) the nature of the disability (i.e. diagnosis), 2) the anticipated length of the disability, 3) the estimated return to work date, and 4) the date when the doctor first saw you for the medical treatment associated with the disability. Any subsequent certifications must include 1) the current nature of disability, 2) the anticipated length of disability, and 3) any new estimated return to work date.

To be eligible for **Non-Work-Related Disability Benefits**, you must meet the following requirements:

1. You must be totally disabled (be completely unable to perform each and every duty of your occupation or employment); and

2. You must be covered under the Plan on the date your disability begins; and

3. Your disability must begin and you must see a doctor about the disability within fifteen (15) days after the last day you worked for an Employer. You must provide a doctor's certification to the Plan stating that you are totally disabled for at least ten (10) days. The initial doctor's certification must include 1) the nature of the disability (i.e. diagnosis), 2) the anticipated length of the disability, 3) the estimated return to work date, and 4) the date when the doctor first saw you for the medical treatment associated with the disability. Any subsequent certifications must include 1) the current nature of disability, 2) the anticipated length of disability, and 3) any new estimated return to work date.

PERIOD OF PAYMENT/WHEN BENEFITS START

Work-Related Benefits are payable as follows:

A) Initial Work-Related Disability Benefits – You shall be paid a lump-sum amount of $2,000.00 for any disability lasting at least ten (10) days but less than thirty (30) days.

B) Secondary Work-Related Disability Benefits – You shall be paid a lump-sum amount of $5,000.00 for a disability lasting more than twenty-nine (29) days but less than ninety (90) days. Said payment shall be in addition to any Initial Disability Benefit payment made to you.

C) Final Work-Related Disability Benefit – You shall be paid a lump-sum amount of $5,000.00 for a disability lasting at least ninety (90) days. Said payment shall be in addition to any Initial and Secondary Disability Benefit Payments made to you.

A disability will not be considered to have started until the first day you are actually examined or treated by a doctor or legally qualified physician.

Non-Work-Related Benefits are payable as follows:

A) Initial Non-Work-Related Disability Benefits – You shall be paid a lump-sum amount of $2,000.00 for any disability lasting at least ten (10) days but less than thirty (30) days.

B) Secondary Non-Work-Related Disability Benefits – You shall be paid a lump-sum amount of $5,000.00 for a disability lasting more than twenty-nine (29) days but less than ninety (90) days. Said payment shall be in addition to any Initial Disability Benefit payment made to you.

C) Final Non-Work-Related Disability Benefit – You shall be paid a lump-sum amount of $5,000.00 for a disability lasting at least ninety (90) days. Said payment shall be in addition to any Initial and Secondary Disability Benefit payments made to you.

A disability will not be considered to have started until the first day you are actually examined or treated by a doctor or legally qualified physician.

PARENTAL LEAVE BENEFITS

The Plan will provide parental leave benefits to you for up to six (6) weeks of parental leave for the birth or placement of a child for adoption or foster care, provided that you provide appropriate documentation to evidence such event. The appropriate documentation includes a birth certificate, adoption paperwork, or a court order or agency paperwork for foster care. If you elect to take time off before the birth of a child, you must provide a doctor's note that documents the pregnancy and the anticipated due date.

The Plan will provide $400 a week for up to a six (6) week period, made in monthly installments. You may commence the parental leave benefits up to two (2) weeks prior to the birth or placement of child for adoption or foster care once you stop working for an Employer. The parental leave benefit is only available for you and not available for your spouse. You may apply for the parental leave benefit through an Application form provided by the Plan upon request.
ELIGIBILITY FOR PARENTAL LEAVE BENEFITS

To be eligible for Parental Leave Benefits, you must meet the following requirements:

1. You must be taking a leave of absence from work for the birth or placement of a child for adoption or foster care; and

2. You must be covered under the Plan on the date such leave begin

D. Death Benefit (For Work Related Deaths Only) $50,000.00

<u>Contributions</u>

The Plan shall be funded solely by employee contributions (after-tax) of $.05 cents per hour worked.

****

<u>PROOF OF CLAIMS</u>

Written proof of claims for payment of benefits should be submitted as soon as you become disabled. **<u>All claims must be filed within 180 days from initial the date of disability (for disability benefit claims) or within one (1) year from the date of death (for death benefit claims) and if they are not submitted, they will be denied as untimely.</u>**

Please keep in mind that his is a very basic summary of the IBEW Local 1245 Injured Workers Plan and is by no means a complete summary of such plan. If you would like a complete Summary Plan Description (SPD) please contact the Local Union Hall directly. Also, the plan provisions mentioned above are subject to change.

IBEW Local 1245 Injured Workers Plan
APPLICATION FOR BENEFITS

(This application must be competed and signed by the Participant. A doctor's certification as described below must be submitted with the application.)

NAME: ______________________________

SOCIAL SECURITY NO.: ______________________________

IBEW CARD NO.: ______________________________

ADDRESS: ____

PHONE NUMBER: ______________________________

APPLICATION FOR: *Choose one of the following*
_____WORK- RELATED DISABILITY BENEFITS

_____NON-WORK-RELATED DISABILITY BENEFITS

_____PARENTAL LEAVE BENEFITS

INTITAL ELIGIBILTY REQUIREMENTS
You will become initially eligible on the first day of the benefit month, corresponding to the eligibility month in which you first accumulate at least 125 credited hours of employment for which an employer is required to make a contribution to the injured workers fund on your behalf. Once you have met the initial eligibility rules, you will remain eligible for coverage for each month in which you have contributions made for at least 100 hours of work (performed in the prior month) or 450 hours of work (performed in the six (6) months prior).

WORK-RELATED AND NON-WORK RELATED DISABILITY BENEFITS
In order to be eligible for Work-Related and Non-Work Related Benefits, you must meet three requirements below AND submit the required documentation.

Eligibility

1. You must be totally disabled and be completely unable to perform each and every duty of your occupation or employment (For Work-Related Disability: as a result of an occupational bodily injury or sickness, which is related to you performing work with an employer signatory to the California Outside Line Construction Agreement); and
2. You must be eligible for benefits and covered under the Plan on the date your disability begins; and
3. Your disability must begin and you must see a doctor about the disability within fifteen (15) days after the last day you worked for an Employer.

Required Documentation
You must provide a doctor's certification with this Application for Work-Related and Non-Work Related Disability Benefits stating:

- You are totally disabled for at least 10 days

- The nature of the disability (i.e. diagnosis)
- The anticipated length of disability
- The estimated return to work date
- The date in which the doctor first saw you for treatment associated with the disability

PARENTAL BENEFITS
In order to be eligible for Parental Benefits, you must the two requirements below AND submit the required documentation.

Eligibility
1. You must be taking a leave of absence from work for the birth or placement of a child for adoption or foster care; and
2. You must be covered under the Plan on the date such leave begins.

Required Documentation
You must submit the following applicable documentation with this Application:
- You must provide documentation that evidences the birth or placement of child for adoption or foster care, including a birth certificate, adoption paperwork, or a court order or agency paperwork for foster care.
- If you elect to take time off before the birth of the child, you must provide a doctor's notes that documents the pregnancy and the anticipated due date.

PROOF OF CLAIMS
Written proof of claims for payment of benefits should be submitted as soon as you become disabled. **All claims must be filed within 180 days from initial the date of disability (for disability benefit claims) or within one (1) year from the date of death (for death benefit claims) and if they are not submitted, they will be denied as untimely.**

EMPLOYER INFORMATION
DATE OF INJURY/ILLNESS: ___________________________________

EMPLOYER AT THE TIME OF LEAVE: _____________________________________

LAST DATE WORKED FOR EMPLOYER: ____________________________________

*START DATE OF LEAVE: ________________ *END DATE OF LEAVE _______________
*(*FOR PARENTAL LEAVE BENEFITS)*

SEND THIS APPLICATION AND THE REQUIRED DOCUMENTS TO:

IBEW Local 1245 Injured Workers Plan
c/o IBEW Local 1245
30 Orange Tree Circle
Vacaville, CA 95687

For additional information, please refer to your Summary Plan Description. If you have any questions, please call (707)452-2720.

SIGNATURE: ______________________________ DATE: ______________________________

IBEW Local 1245 Injured Workers Plan
Disability Certificate

<table>
<tr><td colspan="6">CLAIM FOR DISABILITY BENEFITS – DOCTOR'S CERTIFICATION
(Complete and mail to the below address)</td></tr>
<tr><td colspan="3">1. Patent's Name:</td><td colspan="3">2. Patients Date of Birth:</td></tr>
<tr><td colspan="3">3. Doctor's Name as Shown on License:</td><td colspan="3">4. Doctor's State License Number:</td></tr>
<tr><td colspan="3">Doctor's Telephone Number:</td><td colspan="3">Doctor's Fax Number:</td></tr>
<tr><td colspan="6">5. Doctor's Address (Street, City, State & Zip Code) – P.O. Box is not accepted as the sole address:</td></tr>
<tr><td colspan="2">6. Date Disability Began? (Required)</td><td colspan="2">7. First Treatment Date After Last Workday? (Required)</td><td colspan="2">8. Is condition due to:
☐ Illness ☐ Injury
☐ Work-related</td></tr>
<tr><td colspan="3">9. If patient was hospitalized provide dates of entry and discharge:</td><td colspan="3">10. Anticipated Length of Disability (Required):</td></tr>
<tr><td colspan="3">11. Estimated Return to Work Date (Required):</td><td colspan="3">12.Acutal Return to Work Date:</td></tr>
<tr><td colspan="6">13. Diagnosis (Required) – if no diagnosis has been determined, enter objective findings of detailed statement of symptoms:</td></tr>
<tr><td colspan="6">14. Goals/Treatments:</td></tr>
<tr><td colspan="6">Doctor's Certificate and Signature (REQUIRED): Having considered the patient's regular or customary work, I certify under penalty of perjury that based on my examination, this Doctor's Certificate truly describes the patient's disability (if any) and the estimate duration thereof. I further certify that I am a:

(Type of Doctor) (Specialty if Any) (Licensed to Practice in the State of)

(ORIGINAL SIGNATURE OF ATTENDING DOCTOR – RUBBER STAMP IS NOT ACCEPTABLE) (DATE)</td></tr>
</table>

Please Return the Completed Form to:

IBEW Local 1245 Injured Workers Plan
30 Orange Tree Circle
Vacaville, CA 95687