IBEW LOCAL 6 MEMBER BENEVOLENT FUND
APPLICATION FOR FINANCIAL RELIEF

(Limited to Amount of Outstanding Expenses Up to a Maximum of $3,000 Per Member Effective 1/1/2024)

1. IBEW Local 6 Member_____

2. Address: _____ City: _____ Zip: _____

3. Phone: _____ Email Address: _____

4. Date of Birth: _____

If this is a Claim for financial relief resulting from the death of an IBEW Local 6 Member, attach copy of Death Certificate and skip to Question 14 below:

5. Name of last Employer and Last Date of Covered Employment: _____
_____

6. Type of Injury/Illness: _____

7. Date of Onset and Cause of Injury or Illness: _____
_____

8. What is the Amount of your Unpaid Medical Bills? _____
_____
(Please attach copies of any itemized bills received from hospitals/providers/doctors that show patient liability.)

9. Has your injury or illness prevented you from working in Covered Employment? _____

If Yes, please explain why and how long you have been out of work because of the injury and/or how long you anticipate being out of work? (Attach any doctor's opinion that addresses your injuries and time off from work.)
_____
_____
_____

10. If this claim for financial relief is being filed for reasons other than unpaid medical bills due to injury or illness (such as installment debts or mortgage payments, please provide a description and attach copies of billing statements to support the claim).
_____
_____
_____

11. List below, information concerning disability and workers compensation benefits that were paid, or are payable to you, as a result of this illness or injury:
_____
_____
_____

12. When do you anticipate returning to Covered Employment? _____

13. What other assets do you have (such as bank accounts or investments)? (Attach a list or description including the value of such)

_____
_____
_____

Answer The Questions Below If You Are Seeking Financial Assistance As A Result Of The Death Of An IBEW Local 6 Member.

14. Name/Address of Closest Surviving Relative or Executor of the Estate of the Decedent who is filing this application.

_____
_____
_____

16. What is the Applicant's Relationship to the Deceased Member:_____

17. Date of Death: _____

18. Cause of Death: _____

19. What is the Amount of the Deceased's Unpaid Medical Bills? _____

(Attach copies of itemized bills received from hospitals/providers/doctors that includes patient liability.)

20. What is the amount needed to cover burial and/or funeral expenses for the deceased member?

_____
(attach copy of bill(s))

21. If this claim for financial relief is being filed for reasons other than unpaid medical bills or burial expenses (e.g. installment debts, mortgage payments), please provide a description below and attach copies of billing statements to support the claim.

_____
_____
_____

22. List below, information concerning life insurance, death benefits, or other amounts that were paid, or are payable to the Estate or family of the decedent. Include the sources of these benefit/donations and amounts below:

_____
_____
_____

Dated: _____ Signature: _____

Return to: IBEW Local 6 Members Benevolent Fund, 720 Market St., San Francisco, CA 94102.