IBEW LOCAL 332 TRUST FUND SHORT TERM DISABILITY PLAN
APPLICATION FOR WEEKLY INDEMNITY BENEFITS

Return completed form to:
UNITED ADMINISTRATIVE SERVICES
P. O. Box 5057 - San Jose, CA 95150

Phone No _____

PART I - To be completed by INSURED EMPLOYEE (each question must be fully answered)

1. Name _____ 2. Birthdate _____ S.S.# _____
3. Address _____ City, State, Zip _____
4. Last Employer Name _____
5. Date Last Worked _____ 6. Occupation _____
7 If not employed at the time the disability began, were you signed on the out of work list? Yes _____ No _____
   If No, Please explain _____
8. My disability is _____ Illness? _____ Injury? _____
9. It happened: Date _____ At Work? _____ It ended (or is expected to end) _____
   Time _____ At Home? _____ Date _____
10. How did it happen? _____

To Physicians and Hospitals and Other Insititutions: I hereby authorize you by this form (or photographic copy hereof) to give to IBEW Local 332 Trust Fund any information you have regarding my medical history and physical condition. I certify the above answers are true and complete to the best of my knowledge and belief.

Dated _____ _____
Signature - Please do not print.

I hereby request extended coverage without deduction from my employee account for a period of twelve (12) months immediately following the last day of the month following the month in which my disability commenced. I understand that the twelve (12) months are a lifetime maximum, and that application for extended coverage is subject to approval by the Trustees.

Date _____ _____
Signature

PART I I - ATTENDING PHYSICIAN'S STATEMENT

1. Nature of sickness or injury (Describe complications if any) _____
2. Was this sickness or injury caused by patient's employment? YES _____ NO _____ Illness? _____ Injury? _____
   Was it aggravated by Patient's employment? YES _____ NO _____ IF "YES" explain _____
3. Nature of surgical procedure, if any (Describe fully) _____
4. Date performed _____, YR. _____
5. Give dates of treatments:

	First Consultation	Other Consultations During This Period of Disability
Office		
Home		
Hospital		

6. The patient has been continuously disabled (unable to work) from _____, YR. _____
   through _____, YR. _____
   If still disabled, when should patient be able to return to work? _____, YR. _____
7. Remarks _____

DATED _____ SIGNED _____ DEGREE _____
ADDRESS _____

PART I I I - TO BE COMPLETED BY ADMINISTRATOR

EFFECTIVE DATE OF INSURANCE _____ VERIFIED BY _____