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

EFFECTIVE DATE OF ISURANCE

PART I: TO BE COMPL	ETED BY INSUREI	O EMPLOYEE (EACH Q	UESTION MUST BE FULLY	ANSWERED)
. NAME		2. BIRTHDATE		SS#:
ADDRESS		CITY,	STATE, ZIP	
LAST EMPLOYER NAME _				
DATE LAST WORKED		6. OC	CUPATION	
IF NOT EMPLOYED AT TH	IE TIME THE DISABILIT	TY BEGAN, WERE YOU SIGNI	ED ON THE OUT OF WORK LIST? Y	YES () NO ()
IF NO, PLEASE I	EXPLAIN:			
MY DISABILITY IS			ILLNESS?	INJURY?
. IT HAPPENED:	DATE	AT WORK?	IT ENDED (OR IS EXPECTED TO	END)
	TIME	AT HOME?	DATE	
). HOW IT HAPPENED? ——				
RUST FUND ANY INFORMAT	ION YOU HAVE REGARD			RAPHIC COPY HEREOF) TO GIVE TO IBEW LOCAL 332 IFY THE ABOVE ANSWERS ARE TRUE AND COMPLETE
O THE BEST OF MY KNOWLE	DGE AND BELIEF.			
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