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

PART I: TO BE COMPLETED BY INSURED EMPLOYEE (EACH QUESTION MUST BE FULLY ANSWERED)

1. NAME _____ **2. BIRTHDATE** _____ **SS#:** _____

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 IT HAPPENED? _____

TO PHYSICIANS AND HOSPITALS AND OTHER INSTITUTIONS: 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.

DATE _____ **SIGNATURE** _____

I HEREBY REQUEST EXTENDED COVERAGE WITHOUT DEDUCATION FROM MY EMPLOYEE ACCOUNT FOR A PERIOD OF TWELVE (12) MONTHS IMMEDIATLY FOLLOWING THE LAST DAY OF THE MONTH FOLLOWING THE MONTH IN WHICH MY DISABILITY COMMENCED. I UNDERSTAND THAT THE TWLEVE (12) MONTHS ARE A LIFETIME MAXIMUM, AND THAT APPLICATION FOR EXTENDED COVERAGE IS SUBJECT TO APPROVAL BY THE TRUSTEES.

DATE _____ **SIGNATURE** _____

PART II: ATTENDING PHYSICIAN'S STATEMENT

1. NATURE OF SICKNESS OR INJURY (DESCRIBE COMPLICATIONS IF ANY) _____

2. WAS THE SICKNESS OR INJURY CAUSED BY PATIENT'S EMPLOYEMNT? YES ☐ **NO** ☐ **ILLNESS?** _____ **INJURY?**

WAS IT AGGRIVATED BY PATIENT'S EMPLOYMENT? YES ☐ **NO** ☐ **IF YES, PLEASE EXPLAIN:** _____

3. NATURE OF SURGICAL PROCEDURE, IF ANY (DESCRIBE FULLY)

4. DATE PERFORMED _____ **YEAR**

5. GIVE DATES OF TREATMENTS: FIRST CONSULTATION: **OTHER CONSULTATIONS DURING THIS PERIOD OF TIME:**

OFFICE _____
HOME _____
HOSPITAL _____

6. THE PATIENT HAS BEEN CONTINUOUSLY DISABLED (UNABLE TO WORK) **FROM** _____ **YEAR**
THROUGH _____ **YEAR**
IF STILL DISABLED, WHEN SHOULD PAITENT BE ABLE TO RETURN TO WORK? _____ **YEAR**

7. REMARKS

DATED **SIGNED** **DEGREE**

ADDRESS

PART III: TO BE COMPLED BY ADMINISTRATOR

EFFECTIVE DATE OF ISURANCE _____ **VARIFIED BY** _____