LOCAL #467 SHORT TERM DISABILITY BENEFIT

Member has to be **insured** at the time of the accident OR sickness. This benefit consists of a payment of **$100.00 per week**, up to a maximum of **26 weeks,** and covers the member and his/her family under U.A. Local #467 Health & Welfare Trust Fund **free of charge** for up to a maximum of **12 months,** if needed. Also, it **freezes** the Hours in the member's **Reserve of Hours Account** if any.

If the member has made any payments under the Low Reserve/Unemployed Provision of the Plan in the last **24 months,** the number of months of eligibility for Short term disability will be reduced by the number of **payments.**

RULE: ONLY 12 MONTHS IN ANY 24 MONTHS OF DISABILITY OR REDUCED PREMIUM.

U.A. LOCAL 467 SHORT TERM DISABILITY PLAN

(Weekly Indemnity)

Return completed form to:

United Administrative Services
P.O. Box 5057 - Zip 95150
6800 Santa Teresa Blvd. Ste 100
San Jose, CA 95119

PART I - To be completed by INSURED EMPLOYEE (Each question must be fully answered) Members Phone# _____

1. Name _____ 2. Birth date _____ SSN _____

Street _____ City and State _____ Zip _____

3. Last date of work before disability _____ 4. My disability is _____

Injury? NO Illness? NO 5. It happened: Date _____ Time _____

At Work? ☐ At home? ☐ 6. How did it happen? _____

To Physicians and Hospitals and Other Institutions: I hereby authorize your by this form (or by photographic copy hereof) to give Local 467 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 _____ Mr. ☐ Mrs. ☐ Miss ☐ _____

SIGNATURE – Please Do Not Print

PART II – 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? NO Injury? NO

Was it aggravated by patient's employment? If "Yes" explain _____

_____

3. Nature of surgical procedure, if any (Describe fully) _____

_____

4. Date performed: _____
5. Give dates of treatments:
FIRST CONSULTATION – Office _____ Home _____ Hospital _____

Other Consultations – Office _____ Home _____ Hospital _____

6. The patient has been continuously disabled (unable to return to work) from date _____ through date _____

7. Remarks _____

DATED _____ Physician's Name (Print) _____ Degree _____

Physician's Signature _____

Address _____

Physician's Phone Number _____

PART III – TO BE COMPLETED BY ADMINISTRATOR

EFFECTIVE DATE OF INSURANCE _____ VERIFIED BY _____