

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 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 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: OFFICE _____ HOME _____ HOSPITAL _____ OTHER CONSULTATIONS DURING THIS PERIOD OF TIME: _____

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 COMPLETED BY ADMINISTRATOR

EFFECTIVE DATE OF ISURANCE _____ VARIFIED BY _____