# I.B.E.W./N.E.C.A. SOUND & COMMUNICATIONS HEALTH & WELFARE 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 95150-5057

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 Institutions: I hereby authorize you by this form (or photographic copy hereof) to give to I.B.E.W./N.E.C.A. Sound & Communications Health & Welfare 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.

Date _____ _____
Signature

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PART II - ATTENDING PHYSICIAN'S STATEMENT

1. Nature of sickness or injury causing disability: (Describe complications, if any)_____
2. Was this disability caused by patient's employment? YES_____ NO_____ Illness?_____ Injury?_____
   Was this disability aggravated by Patient's employment? YES_____ NO_____ If "YES", explain _____
3. Nature of surgical procedure, if any (Describe fully) _____
4. Date performed _____, 19_____.
5. Give dates of treatments:

| | **First Consultation** | **Other Consultations During This Period of Disability** |
|---|---|---|
| Office | _____ | _____ |
| Home | _____ | _____ |
| Hospital | _____ | _____ |

6. The patient has been continuously disabled from his/her occupation* from _____, 19_____
   through _____, 19_____
   If still disabled, when should patient be able to return to work?_____, 19_____

   *The employee's job requires the following: 1) Lifting 50 or more pounds at a time; 2) Standing for prolonged periods of time - 6 hours per day, 2 hours at a time; 3) climbing ladders.
7. Remarks_____

DATED _____ SIGNED _____ DEGREE _____
ADDRESS _____

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PART III - TO BE COMPLETED BY ADMINISTRATOR

EFFECTIVE DATE OF INSURANCE _____ VERIFIED BY_____