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 lo the best of my knowledge and belief.

Signature: _____ Date: _____

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 _____, YR. _____
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 _____, YR. _____
   Through _____, YR. _____
   If still disabled, when should patient be able lo return to work? _____, YR. _____
   *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_____

PART III -TO BE COMPLETED BY ADMINISTRATOR
EFFECTIVE DATE OF INSURANCE _____ VERIFIED BY _____