Mail: P. O. Box 4100 · Concord, CA 94524-4100
Telephone: (800) 552-2400 · Facsimile: (925) 746-7549
www.ufcwtrust.com

APPLICATION FOR EXTENDED MEDICAL BENEFITS

(PPO Plan Members Only)

(Extension of Medical Benefits for a Specific Disability— this application form must be returned within 60 days following the expiration of your Disability Extensions or within 60 days of the time earned coverage terminates)

If you or your Dependent is Totally Disabled at the time *Earned Coverage terminates, medical benefits (including prescription drugs) may be extended; only for treatment of the disabling illness or injury. Prescription charges are covered if they are directly related to the disabling condition and are paid under the Medical plan benefit (i.e. subject to Deductible and Coinsurance).
An Extension will end at the earliest of the following:

- The date you or your Dependent no longer is Totally Disabled;
- 12 months from termination of earned coverage; or
- The date you or your Dependent becomes covered under another plan that provides similar benefits for the disabling illness or injury.

*Earned Coverage means only coverage as a result of Employer contributions to the Fund (hours worked or compensated), FMLA or disability extension. COBRA and Self-Pay are not earned coverage, and will run concurrently with this extension of medical benefits.

MEMBER SECTION (TO BE FILLED OUT BY MEMBER ONLY)

1. MEMBER

Member Name PLEASE PRINT:

Last Name: _____ First Name: _____ Middle Initial:_____

Social Security # ___ ___ ___ - ___ ___ - ___ ___ ___ or Member ID # _____

2. PATIENT

Name of Patient PLEASE PRINT:

Last Name: _____ First Name: _____ Middle Initial:_____

Date of Birth: _____/_____/_____
MM DD YYYY

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct and complete. I hereby authorize any physician, any hospital or insurance company to furnish and disclose all known facts concerning this disability. A copy or photocopy of this authorization shall be as valid as the original.

MEMBER SIGNATURE: _____ Date: _____

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PHYSICIAN SECTION (TO BE FILLED OUT BY ATTENDING PHYSICIAN ONLY)

1. DIAGNOSIS

Disability that prevents the above patient from working or attending school: _____

2. HISTORY When did symptoms for illness first appear or injury happen? _____/_____/_____
MM DD YYYY

3. PROGRESS Recovered ☐ Improved ☐ Unimproved ☐ Retrogressed ☐

4. EXTENDED DISABILITY

	For Attending Work/School		For Any other Occupation	
(a) Is patient now totally disabled?	Yes	No	Yes	No
(b) If "Yes", when did patient become totally disabled?	_____/_____/_____ MM DD YYYY		_____/_____/_____ MM DD YYYY	
(c) If "Yes", when will patient be able to resume *any* work/school?	_____/_____/_____ MM DD YYYY		_____/_____/_____ MM DD YYYY	
(d) (d) If "No", when was patient last able to go to work/school?	_____/_____/_____ MM DD YYYY		_____/_____/_____ MM DD YYYY	

REMARKS: (PLEASE PRINT)

Attending Physician's SIGNATURE: _____ Date: _____

Federal ID#: _____ Telephone #: _____

Attending Physician's name PLEASE PRINT: _____ Degree:_____

Street Address:_____

City:_____ State: _____ Zip Code:_____