UFCW TRUST Working For Your Benefit — UEBT SICK LEAVE CLAIM FORM/DISABILITY EXTENSION APPLICATION

CHECK ONE: ☐ SICK LEAVE ONLY ☐ DISABILITY EXTENSION ONLY ☐ SICK LEAVE AND DISABILITY EXTENSION

PART 1 EMPLOYEE INFORMATION (TO BE FILLED OUT BY EMPLOYEE ONLY)

These sections must be completed by the Employee. Part 1-A and 1-B must be completed prior to the Employer completing their section.

1-A

Last Name	First Name	Initial	Date of Birth:	Social Security #	Home Phone #

Mailing Address	City	State	Zip Code	Check if this address is an address change:
				☐ Date of Address Change: _____ MM/DD/YYYY

1-B

1st Date Absent Due to Disability: (MM/DD/YYYY) _____

Return-to-Work Date: (MM/DD/YYYY) _____

Were you injured on the job? NO ☐ YES ☐ Injury Date: _____ MM/DD/YYYY

1-C

For privacy reasons, this section (1c) may be filled out after the employer completes Part 2.

Did you see a doctor during your disability? NO ☐ YES ☐ **Describe your disability:** _____

1-D

I request Sick Leave payments or Disability Extensions for the days of employment lost because of a disability. I understand that I may be subject to civil and/or criminal penalties for committing a fraudulent insurance act if I knowingly provide any materially false information to, or conceal any material facts from, the Trust Fund with the intent to defraud or mislead the Trust Fund to obtain Disability Extensions. I further authorize any physician or hospital to furnish and disclose all known facts concerning my disability.

Store Name: _____ ( ) - _____ Store Phone #:

EMPLOYEE's Signature: X _____ Date Signed: _____ MM/DD/YYYY

PART 2 EMPLOYER STATEMENT (TO BE FILLED OUT BY EMPLOYER ONLY)

This section must be completed by your Employer. Your Employer may require that only certain authorized signatures be accepted. Please be sure to obtain the proper Authorized Signature. The Employer should indicate the schedule you would have worked had you not been absent due to your disability.

2-A

Regularly Scheduled Work Hours per Week: _____ Hours per week

Hourly Rate: $ _____ Full-Time: ☐ OR Part-Time: ☐

First Day of Absence: (MM/DD/YYYY)

Job Classification:

Date Employee Returned to Work: _____ MM/DD/YYYY

Number of hours employee *would have been scheduled* to work each day during the week of the disability:

HOURS SCHEDULED - WEEK OF DISABILTY

	Sun	Mon	Tue	Wed	Thurs	Fri	Sat
Date:							
Hours:							

Did employee work on first day of paid disability or return to work anytime during this disability?
NO ☐ YES ☐ If YES, hours & dates paid:

Did the employee receive holiday, funeral, birthday or vacation pay during this disability?
NO ☐ YES ☐ If YES, indicate hours & dates paid:

During the claim period was the employee on the night crew?
NO ☐ YES ☐ If YES, give the # of missed shifts:

Was employee injured on the job?
NO ☐ YES ☐ If YES, indicate date of injury:

2-B

THIS SECTION (2-B) DOES NOT NEED TO BE COMPLETED UNLESS THE EMPLOYEE HAS RETURNED TO WORK

List the Employee's Return Schedule (include dates they *would have* worked if they were not out on disability):

HOURS SCHEDULED - RETURN TO WORK SCHEDULE

	Sun	Mon	Tue	Wed	Thurs	Fri	Sat
Date:							
Hours:							

2-C

I, the undersigned, verify that the statements contained herein above under the heading "Employer Statement" are true and correct and I understand that these statements will be presented to the Trustees of UFCW & Employers Benefit Trust used in support of the above named employee's Sick Leave claim. *I understand that any false or fraudulent statement made herein may subject me to penalties as prescribed by law.*

Authorized EMPLOYER'S Name [Print]: _____ Title: _____ ( ) - _____ Employer's Phone #:

Authorized EMPLOYER'S Signature X _____ Date Signed: _____ MM/DD/YYYY

ADDITIONAL SECTIONS ON THE BACK OF THIS FORM

PART 3 **ATTENDING PHYSICIAN'S STATEMENT (TO BE FILLED OUT BY PHYSICIAN ONLY)**

In order to be paid for the first day of disability or to be paid beyond the first week of disability, this section must be completed by your doctor. You MUST be seen by your doctor during your disability to be paid for the first day. Please be sure your doctor provides the date you were treated. Telephone advice does NOT satisfy this requirement. A disability day is defined as any day in which you do not work more than 50% of your scheduled shift. If you work more than 50% of your scheduled shift, this day will not be considered as a disability day and therefore will not be considered as your deductible day when not seen by a physician.

3-A

Patient Name: _____ (Last / First / Middle Initial) Date of Birth: _____ (MM/DD/YYYY)

Patient has been continuously disabled (unable to work) from: _____ (MM/DD/YYYY) through _____ (MM/DD/YYYY) If patient is still disabled, give estimated date patient will be able to return to work: _____ (MM/DD/YYYY)

Date(s) seen by doctor: _____ Diagnosis: _____ Diagnosis Code: _____ Is disability related to pregnancy? NO ☐ YES ☐ ; EDC _____ (MM/DD/YYYY)

Was patient hospitalized? NO ☐ YES ☐ Hospital: _____ (Name) _____ (City) _____ (State) Confined From: _____ (MM/DD/YYYY) To: _____ (MM/DD/YYYY)

3-B

Attending Physician: _____ (Last Name:) _____ (First Name) _____ (Degree)

Address: _____ (Street Address) _____ (City) _____ (State) _____ (Zip Code) ( ) - _____ (Phone Number)

Attending Physician Signature: **X** _____ Date Signed: _____ (MM/DD/YYYY)

IF YOUR ABSENCE LASTS LONGER THAN 7 CALENDAR DAYS, YOU MUST FILE FOR STATE DISABILITY INSURANCE (SDI)

ADDITIONAL IMPORTANT INFORMATION

(1) Disabled more than Seven Calendar Days (Three Calendar Days If Disability Caused by Work) from first day of Absence* - The Trust Fund pays in combination with State Disability Insurance (SDI) or Worker's Compensation (WC) benefits beginning your first week of disability. In order to receive your maximum benefits, you MUST file for SDI or WC and attach one of the following:

- A copy of your SDI Notice of Computation; or
- A Worker's Compensation Benefit Notice

If the Trust Fund receives this form without your SDI statement, the Trust Fund will reduce your Sick Leave benefits by the maximum State Disability benefit. You MUST submit a copy of your first SDI or WC benefit notice to the Trust Fund in order to be paid for any additional benefits that are due. Call the SDI office at (800) 480-3287 for information on SDI filing deadlines. If the amount of SDI or WC that you received was less than what the Trust Fund estimated, the Trust Fund will pay any additional benefits that are due. You will be requested to return any overpayments.

You cannot receive more than 100% of your regularly scheduled wages. SDI and WC pay first toward your regularly scheduled wages. The Trust Fund will pay the difference between your regularly scheduled wages and what SDI or WC pays, as long as you have available Sick Leave hours.

**For example: If you are first absent on a Monday due to a disability and you are still absent the following Monday (more than 7 calendar days), then SDI becomes your primary payer of lost wages. You MUST file for SDI in order to receive your entire Sick Leave Benefit amount, because your disability lasted longer than 7 calendar days.*

(2) Timely Filing Limit - You will be disqualified for the Sick Leave Benefit and/or Disability Extension if you do not file your application by the following deadlines:

- *Disability Extensions*: 60 days from the date you receive your COBRA/ Loss of Eligibility notification for Disability Extension;
- *Sick Leave:* One year from the first day of your disability for Sick Leave Claims.

(3) Eligibility For Disability Extensions - Requirements include the following:

- Your disability must begin during a month in which you are eligible for benefits. Standard Plan participants must also have been eligible for at least twelve months prior to the work month in which you became disabled.
- Your total Qualifying Hours can be a combination of hours not worked due to disability and hours worked. The hours you are unable to work because of your disability plus the hours you actually worked, if any, must equal or exceed the minimum monthly Qualifying Hours in order to maintain eligibility.
- If your disability lasts more than seven calendar days, you must submit proof of your disability. You can request your doctor complete Part 3 or you may attach the notifications you received from State Disability or Workers' Compensation for benefits paid to you for the calendar month(s) for which this extension application is made.
- If your Disability Extension Application is granted but you remain disabled when your extension expires, and you are eligible for additional extensions (please confirm with Member Services if unsure of your eligibility), you must file a new application within 60 days from the date the last Disability Extension expired.

You will receive notification from the Trust Fund Office when your application is processed. For additional information about Disability Extensions and the maximum number allowed, please refer to you Summary Plan Description.

PLEASE MAIL COMPLETED FORMS TO:
UFCW & Employers Benefit Trust
P.O. Box 4100
Concord, CA 94524-4100
Please call Member Services if you have any questions (800) 552-2400