

## Sick Leave / Disability Extension Form Checklist (Valley Drug Plans):

Follow these steps to ensure your form is complete and your claim can be processed quickly

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### Part 1 - EMPLOYEE SECTION (TO BE FILLED OUT BY EMPLOYEE ONLY)

#### 1-A Employee Personal Contact Information

- Check **one** box at the top of the form
- This form should be completed once you have returned to work, or at the end of your first full work week out, whichever occurs sooner. Note: Notify the TFO if you return earlier than the Physician's estimated return date.
- If you are absent more than seven (7) calendar days, you must file for State Disability Insurance (SDI), and SDI Computation Form must be submitted. Note: California Paid Family Leave (PFL) is not acceptable.
- Ensure all fields are completely filled out and legible
- For Disability Extension: Form must be received 60 days from the date your coverage ended or you received the COBRA continuation notice
- If **new address**, ensure to check "Yes" under "Is this an Address Change"

#### 1-B Dates of Illness, Injury, or Disability / Store Information

- Last Day Worked and First Date Absent **must** match the same information in Employer's Section 2-A
- This form should not be completed and turned in prior to first date of the Illness, Injury, or Disability
- If you have returned to work, include the Return-To-Work Date

#### 1-C Illness, Injury, or Disability Information

- Illness, Injury, or Disability must be **your own**; confirm by checking "Yes"
- If this Illness, Injury, or Disability is related to another Sick Leave Claim within 60 calendar days, check "Yes"
- If you were injured on the job, check "Yes" and include the date of injury and any Workers' Compensation information (adjuster's name, computation form, check stubs, etc.)
- If you saw a Physician, Part 3 Physician's Statement must be completed by the Physician or attach your "Doctor's Note" for any disabilities greater than 7 days (**to cover the First Day Absent, you must have 180 hours in your sick leave bank on the last day of the month preceding your disability unless, for surgery or hospitalization**)

#### 1-D Employee Signature (form must be signed and dated)

- For Disability Extension and Sick Leave, **you must sign and date**
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### Part 2 - EMPLOYER SECTION (TO BE FILLED OUT BY EMPLOYER ONLY)

#### 2-A Schedule and Pay Information

- Check the correct box for either a **Sun-Sat** or a **Mon-Sun** schedule
- Ensure the dates for the schedule **match** the days of the week above for Sun-Sat or Mon-Sun
- First Week Schedule must reflect the Employee's **complete** regular schedule (e.g. if Employee is normally scheduled for 40 hours per week, this schedule should reflect 40 hours on the Employee's normal days, and should not be modified for a scheduled appointment or procedure)
- The First Date Absent must fall **within** the First Week Schedule; the calendar day, the dates, and hours must match (this schedule will be used for the duration of this claim)
- After Employee has returned to work, fill out "Date Employee Returned to Work" and Return-to-Work Schedule

#### 2-B Employer's Signature (form must be signed and dated)

- Employer must sign and date** on or after Employee's First Date Absent or after Employee returns to work
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### Part 3 - PHYSICIAN'S STATEMENT (TO BE FILLED OUT BY PHYSICIAN ONLY)

#### 3-A Illness, Injury, or Disability Certification

- Ensure all fields and hospitalization check box are filled out as it pertains to this Illness, Injury, or Disability

#### 3-B Physician's Information (form must be signed and dated)

- Physician must sign and date **on or after the date the Employee was seen for an appointment**

**ADDITIONAL IMPORTANT INFORMATION**  
**For Valley Drug Plans**

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

**(1) Ill, Injured, or Disabled more than Seven Calendar Days (Three Calendar Days If Disability Caused by Work) from first day of Absence\*** - Sick Leave Benefits do not duplicate benefits payable by Workers' Compensation (WC) or State Disability Insurance (SDI). 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 Workers' Compensation Benefit Notice

If the Trust Fund receives this form without your SDI statement and the illness, injury, or disability is greater than seven days, 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. You will be requested to return any overpayments.

You cannot receive more than 100% of your regularly scheduled wages. When integrating with SDI and WC, 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 an illness, injury, or 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 illness, injury, or 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
- *Sick Leave:* One year from the first day of your disability

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

- Return this completed form to the Trust Fund Office within 60 days from the date your coverage ended or you received the COBRA continuation notice. If you do not file your application within the 60-day period, you will be disqualified for a Disability Extension.
- You must have been eligible for at least nine continuous months prior to the work month in which you became disabled. The Plan also requires you to have sufficient qualifying hours to be eligible for benefits. The total required hours can be a combination of hours worked and not worked due to disability. The combination of hours worked and scheduled hours not worked must equal or exceed the minimum qualifying hours.
- 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.
- Gold and Platinum Active participants who suffer a Total and Permanent Disability (as defined by Social Security Administration or other comparable standard) will be eligible for an additional 12-month extension - if they are eligible to receive 12 Disability Extensions. To obtain this extension, you must notify the Trust Fund within 60 days of the date your total disability determination is issued.
- 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 your Summary Plan Description.

**PLEASE MAIL COMPLETED FORMS TO:**

Sick Leave Claims  
P.O. Box 4100  
Concord, CA 94524-4100  
Fax: (925) 746-7549

Please call Member Services if you have any questions: (800) 552-2400





# Sick Leave Claim Form/Disability Extension Application

(For use in all Plans administered by UFCW & Employers Trust, LLC)

Employee Last Name	Employee First Name	Member ID or Last 4 SSN (from Page 1)
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## Part 2 EMPLOYER SECTION (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 Illness, Injury, or Disability.*

<b>2-A</b>	Regularly Scheduled Work Hours Per Week:  Hours Per Week	Hourly Rate:  Pay Rate	Check one: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	<b>FIRST WEEK SCHEDULE: Full Schedule for 1st Week in which Disability Begins.</b> Specify the number of hours employee would have been scheduled to work each day during the first week of the Disability. <b>Check one box for weekly schedule.</b> <input type="checkbox"/> Sun-Sat    Sun    Mon    Tue    Wed    Thu    Fri    Sat <input type="checkbox"/> Mon-Sun    Mon    Tue    Wed    Thu    Fri    Sat    Sun <table border="1" style="width:100%; border-collapse: collapse; margin-top: 5px;"> <tr> <td style="width:10%;">Dates (MM/DD)</td> <td style="width:10%;"></td> <td style="width:10%;"></td> <td style="width:10%;"></td> <td style="width:10%;"></td> <td style="width:10%;"></td> <td style="width:10%;"></td> <td style="width:10%;"></td> <td style="width:10%;"></td> <td style="width:10%;"></td> </tr> <tr> <td># Hours Scheduled</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>	Dates (MM/DD)										# Hours Scheduled									
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	Did Employee work or return to work anytime during this Illness, Injury, or Disability? <input type="checkbox"/> NO <input type="checkbox"/> YES	Did Employee receive any wages since the last day worked (e.g. holiday, vacation, funeral, birthday, etc.) during this Disability? <input type="checkbox"/> NO <input type="checkbox"/> YES	IF YES: HOURS    DATE(S) PAID		IF YES: HOURS    DATE(S) PAID																			
	Was employee injured on the job? <input type="checkbox"/> NO <input type="checkbox"/> YES	Was employee on the night crew during this Disability? <input type="checkbox"/> NO <input type="checkbox"/> YES	IF YES: DATE OF INJURY (MM/DD/YYYY)		IF YES: # OF MISSED SHIFTS																			
	Last Day Employee Worked Prior to Disability (MM/DD/YYYY)	Date Employee Returned to Work (MM/DD/YYYY)	<b>RETURN-TO-WORK SCHEDULE: Completed ONLY if employee has returned to work.</b> List the Employee's Return Schedule (include dates they would have worked if they were not out on Disability). <b>Check one box for weekly schedule.</b> <input type="checkbox"/> Sun-Sat    Sun    Mon    Tue    Wed    Thu    Fri    Sat <input type="checkbox"/> Mon-Sun    Mon    Tue    Wed    Thu    Fri    Sat    Sun <table border="1" style="width:100%; border-collapse: collapse; margin-top: 5px;"> <tr> <td style="width:10%;">Dates (MM/DD)</td> <td style="width:10%;"></td> <td style="width:10%;"></td> <td style="width:10%;"></td> <td style="width:10%;"></td> <td style="width:10%;"></td> <td style="width:10%;"></td> <td style="width:10%;"></td> <td style="width:10%;"></td> <td style="width:10%;"></td> </tr> <tr> <td># Hours Scheduled</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>		Dates (MM/DD)										# Hours Scheduled									
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First Date Absent Due to Disability (MM/DD/YYYY)																								

**Employer's Signature (form must be signed and dated)** *This form should not be completed prior to first date of the Illness, Injury, or Disability.*

<b>2-B</b>	I, the undersigned, verify that the statements contained herein above under the heading "Employer Section" are true and correct and I understand that these statements will be presented to the Trustees of the Trust Fund 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.									
	<table style="width:100%;"> <tr> <td style="width:35%;">Authorized EMPLOYER'S Name (Print)</td> <td style="width:30%;">Title:</td> <td style="width:35%;">Employer's Phone#</td> </tr> <tr> <td colspan="2" style="padding: 5px;">Authorized EMPLOYER'S Signature</td> <td style="padding: 5px;">Date Signed: _____</td> </tr> <tr> <td colspan="2" style="padding: 5px;"><b>X</b></td> <td style="padding: 5px;">MM/DD/YYYY</td> </tr> </table>	Authorized EMPLOYER'S Name (Print)	Title:	Employer's Phone#	Authorized EMPLOYER'S Signature		Date Signed: _____	<b>X</b>		MM/DD/YYYY
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Authorized EMPLOYER'S Signature		Date Signed: _____								
<b>X</b>		MM/DD/YYYY								

## Part 3 ATTENDING PHYSICIAN'S STATEMENT (TO BE FILLED OUT BY PHYSICIAN ONLY)

**UEBT/UCBT Members:** In order to be paid for the first day of your illness, injury, or 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 (does not apply to UCBT Save Mart Office and Yosemite Wholesale Members). 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. (Valley Drug Members: To be eligible for the first day, in this case you must also have 180 hours in your sick leave bank on the last day of the month preceding your disability, unless you are hospitalized or had surgery.)

<b>3-A</b>	Patient Name: _____ Date of Birth: _____ Last                      First                      Middle Initial                      MM/DD/YYYY
	Patient has been continuously disabled (unable to work due to his/her own illness or injury) from: _____ through _____ MM/DD/YYYY                      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: _____
	Was patient hospitalized? <input type="checkbox"/> NO <input type="checkbox"/> YES Hospital: _____ Confined From: _____ to: _____ Name                      City                      State                      MM/DD/YYYY                      MM/DD/YYYY
<b>3-B</b>	Attending Physician: _____ Last Name                      First Name                      Degree
	Address: _____ Phone: _____ Street Address                      City                      State                      Zip
	Attending Physician Signature: <b>X</b> _____ Date Signed: _____

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