1000 Burnett Avenue · Suite 110 · Concord, CA 94520
Mail: P.O. Box 4100 · Concord, CA 94524-4100
Telephone: (800) 552-2400 • Facsimile: (925) 746-7549
www.ufcwtrust.com

UFCW Comprehensive Benefits Trust

EXTENDED DEATH BENEFIT FILING REQUIREMENTS

The Fund may continue your Death Benefit if while covered for active eligibility you become totally disabled before reaching age 60 and remain totally disabled to your death. If you become totally disabled between the ages of 60 and 65 while covered for active eligibility your Death Benefit may be extended one year beyond the date your active coverage terminates.

Extended Death Benefits end at normal retirement age and your beneficiary will not be entitled to an Extended Death Benefit when you die.

The Extended Death Benefit amount and the definition of "totally disabled" are in your Summary Plan Description.

This letter provides you with the procedures that you must follow in order to qualify for the Extended Death Benefit. Please note that the Extended Death Benefit covers the *member only*.

1. You must complete and return the application with proof of total disability **within one year of the loss of your eligibility.** Your application must be returned to the Fund office and **not** your Local Union. Proof of disability may be in the form of:

   - the Trust Fund application accompanied by receipt of a Social Security Disability Income award or receipt of a disability pension, or
   - the Trust Fund application accompanied by a completed Attending Physician's Statement of Disability (attached) that is signed by your Attending Physician.

   If you do not file your application on time, the Extended Death benefit will be forfeited.

2. Once you complete and send in your application, The Fund office will notify you that your application has been received. Call the Fund office if you have not received a response within one month.

   If needed, the Fund office shall request additional information. When a decision has been made, the Fund office will notify you if your application has been approved or denied.

If you became totally disabled between the ages of 60 and 65, the remainder of this announcement does not apply to you. Your Extended Death Benefit will only be extended for one year beyond the end of active eligibility or when you reach normal retirement age; whichever occurs first.

3. If you became disabled prior to age 60, further one-year extensions of the death benefit will be granted after the initial extension if you submit subsequent satisfactory proof (see #1) of your continuing total disability.

   In general, proof of your continuing total disability must be submitted every January. The Fund Office will advise you by mail when subsequent proof is due. If your initial application was approved between January 1 and June 30, you will receive your first notice of the need to file subsequent proof in December. If your initial application was approved between July 1 and December 31, your first notice will be sent the following year in December. Thereafter, proof of total disability must be submitted every January, which will be the common anniversary for all those eligible for continuing death benefit extensions, no matter what the initial filing date.

   Examples: If your initial application is approved in May, proof of ongoing total disability must be provided in January and every January thereafter to continue your extended death benefits.

   If your application is approved in November you would not need to provide proof of ongoing disability in January of the following year but would need to provide proof of ongoing disability every January thereafter to continue your Extended Death Benefits.

4. As mentioned above, if proof of disability is needed from you, the Fund Office will notify you in December of the requirement to file a subsequent death benefit extension during January. If your proof is not received by March 1 of that year, a final reminder notice will be sent to you.

   The Extended Death Benefit will terminate upon the earlier of:

   - 31 days following the date you cease to be totally disabled, or
   - March 31, if you do not file verification or
   - When you reach your normal retirement age.

   The Fund Office will notify you when the Extended Death Benefit ends.

5. The Fund Office may accept proof of your continued total disability after the annual certification date and reinstate the benefit. You must prove that you are still totally disabled when you apply for reinstatement and that your disability was ongoing since the last certification. If you die and your beneficiary requests reinstatement, your beneficiary must prove that you were continuously totally disabled until your death. The death benefit can only be reinstated if the initial application was filed on time (see #1). Again, this only applies to you if you were disabled prior to age 60.

ANNUAL ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

Use this form if Social Security Disability Income (SSDI) is not submitted.

EMPLOYEE'S SECTION:

(Please print)

1. Name of Employee: _____ Soc. Sec. No. _____
Last Name First Name Middle Initial

Sex: _____ Age: _____ Married: Yes ___ No ___ Date of Birth: _____

Print any Previous Name
Under which you filed a claim: _____ Union Local No: _____

2. Home Address: _____
Number and Street City Zip Code

Phone No. _____

3. Nature of present sickness or injury? _____

4. On what date were you first totally disabled by this sickness or injury? _____

5. Have you engaged in any occupation or business since the beginning of this disability? If so, give details (Employer, Address, Date Employed, Job Duties):

_____

_____

6. On what date were you first treated by a physician for this disability? _____

7. Do you now have or have you applied for a Disability Award from Social Security? Yes ___ No ___

Outcome: Approved _____ Denied _____ Still Under Review: _____ Date Applied: _____

Attach copy of Approval or Denial Notice

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION:

I authorize my physician, hospital, or other medically designated facility to furnish the Trust Fund any and all information or records pertaining to my medical history, including services rendered, or treatment given for the purposes of utilization review, quality assurance, surveys, processing of claims, financial audit, or to perform administrative functions. I understand that the Trust Fund, its agents or employees, may need to disclose my confidential information to others. Any such disclosure shall be made in compliance with all applicable laws. The Trust Fund, its agents or employees, shall use all reasonable safeguards to ensure that any use or disclosure of my confidential information is solely for the purpose of administering benefits under the Plan. I declare under penalty of perjury under the laws of the state of California that the information provided herein is true and correct to the best of my knowledge and I consent to the provisions stated above on this form, which I have fully read and understand.

_____
Employee's Signature Date

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

THE PATIENT IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE TRUST FUND

PHYSICIAN'S SECTION (All Questions Must Be Answered)

1. Name of Patient_____ **Age of Patient**_____

2. DIAGNOSIS:

3. HISTORY

(a) Date symptoms first appeared or accident happened _____
(Month Day Year)

(b) Date patient ceased work because of disability _____
(Month Day Year)

4. PRESENT CONDITION

Is patient Ambulatory____ Bed confined____ House confined____ Hospital confined____

5. TREATMENT

Date of first visit _____
(Month Day Year)

Date of last visit _____
(Month Day Year)

Frequency of visits Weekly_____ Month_____ Other_____

Please Note: Annual examination is necessary to determine current health status.

6. PROGRESS

Recovered____ Improved____ Unimproved____ Retrogressed____

7. EXTEND DISABILITY

(a) Is patient now totally disabled? Yes _____ No _____

(b) If not disabled, when was patient able to go to work? _____
(Month Day Year)

(c) If disabled, when do you think patient will be able to resume any work?

Approximate Date _____
(Month Day Year)

Never _____

8. MENTAL CONDITION

Is the patient competent to endorse checks and direct the use of the proceeds thereof? Yes_____ No_____

REMARKS:

Doctor's Signature Fed ID# Date

Doctor's Name – PLEASE PRINT Degree Telephone

Street Address City State Zip Code

In order for your dependent(s) to continue to receive benefits under the UCBT Plan, action is required by you.