

**United Food and Commercial Workers Union Local 1529  
And Employers Health and Welfare Plan and Trust**

**ADMINISTRATIVE OFFICE**

Administrative Consulting Services of Tennessee  
661 N. Ericson Cordova, TN 38018  
Telephone (901)758-3000  
Toll Free (800) 874-8499

**BOARD OF TRUSTEES**

Leon E. Sheppard Jr.  
Peggy Prescott  
Kevin Lindsey  
Rick Slayton

Dear Participant:

You contacted our office inquiring about Short-Term Disability benefits offered through United Food and Commercial Workers Union Local 1529 and Employers Health and Welfare Plan and Trust.

Please be advised that the following action is **required on your part** before we can determine if you are eligible to receive Short-Term Disability Benefits.

1. Part A is to be completed and signed by YOU, the policy holder.
2. Part B is to be completed and signed by your STORE MANAGER or CO-MANAGER.
3. Part C is to be completed and signed by your DOCTOR.

**Final Step:**

**Submit your documents to the Fund Office:**

**Fax: 901-758-3021**

**Mail: 661 N. Ericson Rd. Cordova Tn 38018**

**Upload: [www.bams.bz](http://www.bams.bz)**

**It is YOUR responsibility to provide all forms timely in order for payment.**

MetLife Phone: 1-888-343-6886. They are in charge of handling the paperwork for Kroger to place your job on hold. MetLife is a company Kroger hired; it is not a part of the Union Benefit Office. Please address all MetLife questions with Kroger, their HR, your management or with MetLife. MetLife Fax: 1-800-230-9531

**Non-work-Related Accidents:** Involving cars, businesses, attorneys, other responsible third parties, insurances, lawsuits etc. require SUBROGATION documents to be completed. Benefits are not payable without them

**Workmen's Comp:** If you injured yourself at work, you must contact your Risk Management representatives. The Fund benefits office will NOT consider you for any Short-Term Disability benefits/medical leave pay until you have a minimum of two Workmens' comp denial letters.

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## SHORT TERM DISABILITY INCOME BENEFIT

### Loss of Time Benefit for Employees

Purpose: \*Weekly Disability Income Benefits provide a partial replacement of Eligible Employee's take-home pay as a result of accident or illness.

**Amount of Weekly Benefit for Employees working 36+ hours.....66 – 2/3% of weekly earnings up to a maximum of \$350 per week**

**Amount of Weekly Benefit for Employees working 18-36 hours.....66 – 2/3% of weekly earnings up to a maximum of \$175 per week**

Waiting Period for Accident .....None, benefit accrues from the first full day of absence due to accident  
Waiting Period for Sickness.....7 days, benefit accrues beginning on the 8<sup>th</sup> full day of absence due to illness.

\*Maximum Period of Benefit during Disability..... 26 weeks in any consecutive 12-month period. Must return to work for six consecutive months before this benefit is renewed.

The Plan will pay a Weekly Benefit if you become sick or injured and unable to work provided:

- ✓ You are an Eligible Employee on the date the disability commences;
- ✓ You are Totally Disabled from illness or accident (whether occupational or non-occupational so as to be unable to perform the duties of your employment);
- ✓ You are under the direct and continuing care of a Physician;
- ✓ The Disability is continuously and
- ✓ The Disability extends beyond the expiration of the waiting period, if any. The Eligible Person's Disability must be certified by a Physician, and the Eligible Person must be under the direct and continuing care of a Physician.

### SUCCESSIVE DISABILITIES

- If you again become Totally Disabled after a period for which a Weekly Benefit was paid, the Plan will treat the new Disability period as part of the first one if:
- The new period is due to the same or related cause and you have not been actively at work for more than two consecutive weeks between the two periods: or
- The new period is due to an unrelated cause, and you have not been actively at work at all between the two periods.
- When the second period is treated as part of the first, you will receive payments without another waiting period. When the second period is treated as a new Disability, you must start a new waiting period.

### WORKERS' COMPENSATION

- For occupational accidents or sickness, Weekly Disability Income Benefits offset the difference between the amount of the stated benefits and the amount paid by Workers' Compensation.

**Part A: POLICYHOLDER'S STATEMENT**

**Who Completes? YOU, the employee.**

**\*\*\* IMPORTANT: To be eligible you must be on an approved Leave of Absence from your Employer and working the hours required to qualify.** This packet is NOT for your Employer. Return ALL PARTS to the Fund Office address.

|  |  |                            |   |                      |   |          |
|--|--|----------------------------|---|----------------------|---|----------|
| POLICY HOLDER'S FIRST NAME:  |  | POLICY HOLDER'S LAST NAME: |   | SOCIAL SECURITY/ ID: | DATE OF BIRTH                             | GENDER   |
| POLICY HOLDER'S ADDRESS:   |  |                            | STREET  | CITY/STATE           |   | ZIP CODE |
| E-MAIL ADDRESS:  |  |                            | PHONE NUMBER: (Please include area code)              |                      |   |          |
| <i>*By providing your e-mail address above, you consent to the use of electronic transactions to the extent available and permitted by law</i> |  |                            |   |                      |   |          |
| EMPLOYER NAME:   |  |                            |   | OCCUPATION:          |   |          |
| IS YOUR ACCIDENT OR SICKNESS RELATED TO YOUR OCCUPATION? Circle one: YES or NO   |  |                            | HAS A WORKER'S COMPENSATION CLAIM BEEN FILED? YES/ NO |                      |   |          |
| DATE REPORTED TO YOUR EMPLOYER:  |  |                            | <b>STATUS</b><br>APPROVED<br>PENDING<br>DENIED        |                      | IF DENIED, HAVE YOU FILED AN APPEAL? Y/ N |          |

Special Notes:

**AUTHORIZATION**

For the purpose of evaluating my *eligibility for insurance and eligibility for benefits* under an existing policy/certificate including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application or claim form, I hereby authorize the disclosure of the following information about me with the entities below

**Disclosure of Health Information**

Health information may be disclosed by any health care provider, health plan or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes.

**POLICYHOLDER'S SIGNATURE:**

**DATE:**

FUND OFFICE: Mail or fax forms here –  
 661 N Ericson Road \* Cordova, TN 38018  
 Phone (800) 874-8499 \* Fax 901-758-3021

**Part B: EMPLOYER'S STATEMENT**  
**Who Completes? Your Manager**  
**or Human Resources**

**PART B: EMPLOYER'S STATEMENT: (To be completed by your Store Manager or Human Resources (NOT YOU))**

|                |                    |               |              |
|----------------|--------------------|---------------|--------------|
| EMPLOYEE NAME: | EMPLOYEE ID NUMBER | DATE OF BIRTH | DATE OF HIRE |
|----------------|--------------------|---------------|--------------|

**The questions below are to be answered by your  
 EMPLOYER-NOT YOU, the employee.**

|  |                          |
|--|--------------------------|
| DATE EMPLOYEE WAS ACTUALLY LAST PRESENT AT WORK? | EMPLOYEE HOURLY PAYRATE: |
|--|--------------------------|

WEEKLY HOURS WORKED PRIOR TO LEAVE, PLEASE LIST A MINIMUM OF 4 WEEKS

|   |   |
|---|---|
| DATE THE EMPLOYEE RETURNED TO FULL-TIME WORK OR LIGHT DUTY/PART-TIME: | Prior to the disability was the employee: Laid Off, On Leave, Retired, Discharged, None of these. Please Explain: _ |
|---|---|

|  |  |  |
|--|--|--|
| <b>DID THE CLAIM RESULT FROM JOB ACTIVITY?</b><br>YES or NO                            | HAS A WORKER'S COMPENSATION CLAIM BEEN FILED?<br>NO/ YES | <b>STATUS</b><br><br>APPROVED<br>PENDING<br>DENIED<br><br>IF DENIED, HAS AN APPEAL BEEN FILED? Y/N |
| HAS THE EMPLOYEE RECEIVED ANY OTHER INCOME AS A RESULT OF DISABILITY?<br><br>NO<br>YES |  |  |

**AUTHORIZED EMPLOYER'S SIGNATURE**

|   |   |             |
|---|---|-------------|
| COMPANY NAME:                                     | TELEPHONE NUMBER:   | FAX NUMBER: |
| ADDRESS:  | NAME AND TITLE OF PERSON COMPLETING THIS FORM (EMPLOYER): |             |
| SIGNATURE OF AUTHORIZED EMPLOYER REPRESENTATIVE : | DATE:   |             |

FUND OFFICE: Mail or fax forms here -  
661 N Ericson Road \* Cordova, TN  
38018 Phone (800) 874-8499 \* Fax  
901-758-3021

**Part C: PHYSICIAN'S STATEMENT**  
**Who Completes? Your Doctor.**

**PART C: ATTENDING PHYSICIAN'S STATEMENT:** (To be completed by physician certifying disability on or after disability date to avoid processing delays)

|  |   |   |
|--|---|---|
| PATIENT'S NAME:  |   | DATE OF BIRTH:  |
| DATE PATIENT BECAME DISABLED DUE TO PRESENT DIAGNOSIS: | WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT OCCUR?                                 | HAS THE PATIENT EVER HAD SAME OR SIMILAR CONDITION/ DIAGNOSIS?<br><b>YES/ NO</b><br>DATE: _____ |
| IS THIS A WORKER'S COMPENSATION INJURY?<br>NO/ YES     | NAMES/ADDRESSES ANY ADDITIONAL PHYSICIANS TREATING PATIENT FOR CURRENT DIAGNOSIS: |   |
| IF "YES," DATE ACCIDENT OCCURRED:                      |   |   |

**DIAGNOSIS**

|  |                         |  |
|--|-------------------------|--|
| DIAGNOSIS:<br>(INCLUDING COMPLICATIONS)        | ICD CODE (S):           | SUBJECTIVE SYMPTOMS:<br><br><b>OBJECTIVE FINDINGS</b> (INCLUDING CURRENT X-RAYS, EKG'S, LA BORATORY DATA AND ANY CLINICAL FINDINGS.) |
| PREGNANCY:<br><br>EDC: _____<br><br>LMP: _____ | DATE OF DELIVERY: _____ | PLEASE LIST ANY PREGNANCY COMPLICATIONS:   |

**TREATMENT**

|  |  |
|--|--|
| **Starting Date of Disability:<br>_ (Month) (Day) (Year)   | ***Ending Date of Disability: (Month) (Day) (Year)   |
| NATURE OF TREATMENT (SURGERY AND MEDICATIONS PRESCRIBED, IF ANY.)<br><br>FREQUENCY OF TREATMENT: | DID PATIENT HAVE SURGERY?<br><br>IF YES:<br><b>DATE OF SURGERY:</b><br><b>TYPE OF SURGERY:</b> |

Special Notes:

|                             |             |                   |                    |
|-----------------------------|-------------|-------------------|--------------------|
| NAME: (ATTENDING PHYSICIAN) | FAX NUMBER: | TELEPHONE NUMBER: | MEDICAL ID NUMBER: |
| ADDRESS:                    | CITY:       | STATE:            | ZIP CODE:          |

**AUTHORIZED SIGNATURE OF PHYSICIAN**

"I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief."

|                   |              |
|-------------------|--------------|
| <b>SIGNATURE:</b> | <b>DATE:</b> |
|-------------------|--------------|