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 Rd. Cordova, TN 38018
Telephone (901)758-3000
Toll Free (800) 874-8499

Contact our office at 901-758-3000 immediately!

A trained Specialist will assist you with understanding how to complete the enclosed forms.

Incomplete forms or forms filed incorrectly can create major delays in you receiving applicable benefits!!!

FOR YOUR RECORDS

(YOU KEEP THIS)

SHORT TERM DISABILITY INCOME BENEFIT

Loss of Time Benefit for Full-Time 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……..66 – 2/3% of weekly earnings up to a maximum of $160 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 8th 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 a full-time 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.

UFCW Lo. 1529 and Employers Health and Welfare Plan and Trust
FUND OFFICE: *Mail or fax forms here* - 661 N Ericson Road * Cordova, TN 38018
Phone (800) 874-8499 * Fax 901-758-3021

SHORT TERM DISABILITY CLAIM FORM

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 receiving Full-Time benefits. 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	ZIP CODE

E-MAIL ADDRESS:	PHONE NUMBER: (Please include area code)

**By providing your e-mail address above, you consent to the use of electronic transactions to the extent available and permitted by law*

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:	**STATUS** ☐ APPROVED ☐ PENDING ☐ DENIED **IF DENIED**, HAVE YOU FILED AN APPEAL? Y/ N

Special Notes:

AUHTHORIZATION

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:**

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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'S 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?	
DATE THE EMPLOYEE RETURNED TO FULL-TIME WORK OR LIGHT DUTY/PART-TIME:	Prior to the disability was the empolyee: Laid Off ___, On Leave___, Retired___, Discharged____, None of these____. Please Explain: _____

DID THE CLAIM RESULT FROM JOB ACTIVITY?
YES or NO

HAS A WORKER'S COMPENSATION CLAIM BEEN FILED?
NO/ YES

STATUS

- ☐ APPROVED
- ☐ PENDING
- ☐ DENIED

IF DENIED, HAS AN APPEAL BEEN FILED? Y/ N

HAS THE EMPLOYEE RECEIVED ANY OTHER INCOME AS A RESULT OF DISABILITY?

- ☐ NO
- ☐ 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:**

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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? **YES/ NO** DATE: _____
IS THIS A WORKER'S COMPENSATION INJURY? NO/ YES IF "YES," DATE ACCIDENT OCCURRED:	NAMES/ADDRESSES ANY ADDITIONAL PHYSICIANS TREATING PATIENT FOR CURRENT DIAGNOSIS:	

DIAGNOSIS

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

TREATMENT

**Starting Date of Disability: ____(Month)____(Day) _____(Year)	***Ending Date of Disability:____(Month)____(Day) _____(Year)
NATURE OF TREATMENT (SURGERY AND MEDICATIONS PRESCRIBED, IF ANY.) FREQUENCY OF TREATMENT:	DID PATIENT HAVE SURGERY? IF YES: **DATE OF SURGERY**: **TYPE OF SURGERY**:

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."

SIGNATURE: **DATE:**