

APPLICATION FOR ELIGIBILITY EXTENSION BECAUSE OF TOTAL DISABILITY—PLATINUM AND GOLD PLAN PARTICIPANTS

INSTRUCTIONS:

1. 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 this 60-day period, you will be disqualified for a Disability Extension.
2. You must have been eligible for at least nine continuous months prior to the work month in which you became disabled. The Plan also required you to have sufficient qualifying hours to be eligible for benefits. The total required hours can be a combination of hours worked and hours not worked due to disability. The combination of hours worked and scheduled hours not worked must equal or exceed the minimum qualifying hours.
3. If your disability is more than seven calendar days, you must submit proof of your disability. You can request your doctor to complete Part B 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.
4. An application must be submitted for each month you are disabled.
5. You will receive notification from the Trust Fund office when your application is processed. For additional information about Disability Extensions please refer to your Summary Plan Description.

PART A: Participant to Complete (Please Print)

PARTICIPANT NAME: _____ UNION LOCAL #: _____ SOCIAL SECURITY #: _____ - _____ - _____
 STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
 Check if this is an address change: Date of change _____
MM/DD/YYYY
 BIRTH DATE: _____ HOME PHONE #: _____
MM/DD/YYYY
 EMPLOYER: _____
 STORE ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
 DATE OF LAST WORK: _____ DATE YOU EXPECT TO RETURN TO WORK: _____
MM/DD/YYYY MM/DD/YYYY

THIS SECTION MUST BE COMPLETED BY EMPLOYEE IN FIRST MONTH OF DISABILITY ONLY

Indicate days and number of hours scheduled to work the first week of disability
 WEEK OF _____ : Sun. _____ Mon. _____ Tues. _____ Wed. _____ Thu. _____ Fri. _____ Sat. _____
 Indicate days and number of hours scheduled to work the second week of disability
 WEEK OF _____ : Sun. _____ Mon. _____ Tues. _____ Wed. _____ Thu. _____ Fri. _____ Sat. _____

I CERTIFY THAT I HAVE BEEN DISABLED AND UNABLE TO WORK AT ANY OCCUPATION IN THE MONTH(S) OF _____
Period of Disability
 I HAVE BEEN PAID VACATION DURING MY DISABILITY.
 I HAVE NOT

I request Disability Extensions for the days of employment lost because of 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.

Signature of Participant: _____ Date Signed _____

PART B: DOCTOR'S CERTIFICATION OF DISABILITY (Please print or type except Signature)

_____ has been under my care due to _____
(Name of Patient)
 and unable to work any occupation from _____ through _____
 If still disabled, give estimated date of return to work _____
 Doctor's Signature _____ Date _____
 Doctor's Name _____ Degree _____ I.D.# _____
 Address _____ City _____ State _____ Zip _____ Phone # _____