

APPLICATION FOR TEMPORARY DISABILITY BENEFITS

PART I - TO BE COMPLETED BY EMPLOYEE

Having been disabled since _____, I hereby apply for Temporary Disability Benefits under the provisions of Section 6.6 of the Plan.

Name _____ Soc.Sec.No. _____

Address _____ Employer _____

_____ Home Telephone _____

Date of Birth _____ Male ___ Female ___ Occupation _____

Describe your job duties _____

Have you returned to work? No Yes Part Time on _____ Full Time on _____

If No, when do you expect to return? Part Time on _____ Full Time on _____

Please provide the name, specialty, address and telephone number of your doctor. Include dates of treatment as indicated.

Name & Specialty _____	Telephone No. _____	Treated From _____	To _____
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Address _____

Is this the only doctor you are seeing for treatment and care? No Yes

If No, attach a list of all other doctors' names, addresses, telephone numbers and specialties.

I hereby certify that the answers I have provided on this form are full, complete and true.

Signature _____ Date _____

PART II - TO BE COMPLETED BY EMPLOYER

Last day worked _____ Expected length of disability _____

If recovered, date returned to work _____

Nature of disability _____ W-2 salary or wages at date of disability _____

Workers' Compensation benefits payable? ___No ___Yes

Disability benefits payable by another employer plan? ___No ___Yes

Job Title _____ Regular Part Time Hours worked/week: _____

Physical requirements of the job: Please circle the number of HOURS spent in each activity daily. Continuously With Rest

Stand	0.25	0.5	1	1.5	2	3	4	5	6	7	8	<input type="checkbox"/>	<input type="checkbox"/>
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Walk	0.25	0.5	1	1.5	2	3	4	5	6	7	8	<input type="checkbox"/>	<input type="checkbox"/>
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Sit	0.25	0.5	1	1.5	2	3	4	5	6	7	8	<input type="checkbox"/>	<input type="checkbox"/>
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Drive	0.25	0.5	1	1.5	2	3	4	5	6	7	8	<input type="checkbox"/>	<input type="checkbox"/>
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Lift/carry:	0.25	0.5	1	1.5	2	3	4	5	6	7	8	<input type="checkbox"/>	<input type="checkbox"/>
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Up to 10 lbs. 11-20 lbs. 21-50 lbs. 51-100 lbs.

Signature _____ Title _____ Date _____

(Note: Must be completed by the President or Treasurer of the Board or authorized designate)