SHORT TERM DISABILITY INCOME APPLICATION

Please send the original claim to:

IUOE • Local 399 Health & Welfare Fund
c/o Elite Administration
310 S. Racine Avenue • Suite 700 • Chicago, IL 60607
For Assistance, Call (312) 372-9870 Ext. #3

Local 399's Health and Welfare Plan provides covered members with a basic level of income if you become disabled and cannot work because of a non-occupational injury or illness. This benefit has a 14-day waiting period and pays $250 per week for a maximum of 26 weeks based upon the length of your disability. This application has three parts to be completed: member, employer and physician.

STATEMENT OF MEMBER

Full Name: ______________________________ H&W ID (or SS#) ____________________
Last First Middle

Street Address: ______________________________ Date of Birth: ______/______/______
Month Day Year

City: ______________________________ State: __________ Zip: ____________________

Home Phone: (_______) ____________-______________ Cell Phone: (_______) ____________-______________

Describe the onset and nature of sickness or how and where an accident occurred:

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Date of First Symptoms or Accident: ______/______/______ Date of First Treatment: ______/______/______
Month Day Year Month Day Year

Date of Surgery *(if applicable)*: ______/______/______ Date(s) of Hospitalization: ______/______/______
Month Day Year Month Day Year

______/______/______

First Full Date of Disability *(unable to work)*: ______/______/______ Date Returned to Work: ______/______/______
Month Day Year Month Day Year

In signing below, I represent that the statements are true, complete and correctly recorded. I authorize any physician, hospital, or other medical professional who has examined me or has records relating to this disability to furnish medical records or requested information to the Fund's Claims Administrator, Elite Administration.

Signature ______________________________ Date____________________

All portions of this claim form must be completed to avoid unnecessary delay in the processing of your request for benefits. If you have any questions when completing this application, please call the Fund Office or Elite Administration at (312) 243-1265. Mail the fully completed form to the Fund's Claims Administrator: Elite Administration, 310 S. Racine Avenue #700, Chicago, IL 60607 or fax both sides to Elite at (312) 243-8678.

Employer & Physician To Complete Reverse Side

STATEMENT OF EMPLOYER

Employee Name: ____ Social Security Number: ________/_________/________

Date of Hire: ________/_________/________ Date Last Worked: ________/_________/________
Month Day Year Month Day Year

Date(s) Employee Unable to Work Due to Disability: ____

Date Returned to Work: ________/_________/________ Occupational Injury? Yes _________ No _________

Employer Name: ____ Job Site: ________________________________

Signature: _______________________________________ Title: _____________________ Date: ______/_______/______
Month Day Year

Name: ____________________________ Telephone: (______) _________- __________ Fax: (______) _________- __________

STATEMENT OF PHYSICIAN

Patient's Name: ____ Date of Birth: ________/_________/________
Month Day Year

Diagnosis and Current Conditions: ____

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Did disability arise from patient's employment: Yes ________ No ________

Non-occupational accident: Yes ________ (*if yes, please specify accident date*: ______/_______/______) No ________
Month Day Year

Date symptoms first occurred: ______/_______/______ Date patient first consulted you: ______/_______/______
Month Day Year Month Day Year

Date patient became unable to work with this disability: ______/_______/______
Month Day Year

Date(s) of surgical procedure, if any : ______/_______/______
Month Day Year

If pregnancy, estimated date of delivery: ______/_______/______
Month Day Year

Date returned to work: ______/_______/______ Or, date patient expected to return to work: ______/_______/______
Month Day Year Month Day Year

Describe any circumstances causing disability to be prolonged: ____

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Physician Signature: ____ Date: ______/_______/______
Month Day Year

Physician Name *(please print)*: ______________________________________ Physician Specialty: _______________________

Street Address: ______________________________________ City: _____________________ State:_____ Zip: ___________

Telephone: (______) ____________- _____________ Fax: (______) ____________- _____________