D-A&B (100107)

To qualify for weekly disability Income you must:

1) Visit a physician within the first three days of illness or injury
2) Be eligible for benefits at the time of disability
3) Be wholly and continuously disabled and unable to perform the duties of your occupation
4) Be under the care of a legally qualified physician
5) Not be engaged in any other occupation for wage or profit during the disability period

Miscellaneous Information

- The service/treatment must be a covered benefit under the Welfare Fund guidelines.

- If your return to work date changes at any time during your disability, you must send in a new Physician note with that date **as soon as possible.** Please call the Fund office at (314) 835-2700 the day you return to work, if it is before the date your physician released you.

- Your Physician must include an approximate date of return to work when completing the original disability form. We can not accept your claim if he/she states "unknown."

- Eligibility begins on: The 1st day of an accident or the 4th day of an illness.

- One week of disability pay is a period of seven days, including the weekend.

- Percentage of payment: 70% of average weekly wage for the 4-week period immediately preceding the disability.
  Maximum weekly benefit amount: at least one year but less than 10 years $250.00
  at least 10 years but less than 20 years $300.00
  20+ years....................................$350.00
- The maximum disability time is 13 weeks.

If disability is due to maternity, the maximum time allowed is as follows. (If you are disabled prior to date of delivery the benefit will not exceed the maximum of 13 weeks).

- 6 weeks after normal delivery
- 8 weeks after a Cesarean delivery

Member Assistance Program (MAP)
The Member Assistance Program can provide support and resources to assist you while you are off work due to a medical disability. The MAP can help you sustain many normalcy's to your lifestyle as possible and offer appropriate resources. Contact the confidential program for assistance at 1-800-765-9124.

If you become disabled, as defined above, during a month that you are eligible for part time benefits you may be eligible to receive an extension of your coverage up to a maximum of three months. Part time eligibility does not include disability income.

D-A&B (100107)

Welfare Fund
Local 655

United Food & Commercial Workers
13537 Barrett Parkway Drive • Ste-100
Manchester, Missouri 63021
(314) 835-2700 • Toll Free (866) 565-2700
Fax (314) 835-2790

WEEKLY INCOME FORM (SHORT TERM DISABILITY)

To be completed by Plan Participant

Member's Name________________________ Social Security No.________________________

Address________________________ Member's Phone________________________

Job Title________________________

Employer________________________ Employer's phone________________________

Describe **illness *or* injury:** ________________________

HOW did injury happen? ________________________

WHEN did injury take place? ________________________

WHERE did injury occur? ________________________

Is there anyone that could have caused this Accident/Injury other than yourself? ________________________
(please describe accident/injury on back of form)

Is your absence a result of an occurrence which took place on the job? ________________________

Has an incident been filed/reported to Workman's Compensation? ________________________

Signature:________________________ Date:________________________

To be completed by Physician

ICD-9 code________________________**Narrative**________________________

Is condition a result of patient's employment? **YES**________________________**NO**________________________

Date first consulted for this condition________________________

Patient has been unable to work from:________________________

Patient's return to work date:________________________

Next appointment:________________________

*IF MATERNITY, PLEASE GIVE EXPECTED DATE OF DELIVERY*________________________

Physician's Name (PLEASE PRINT)________________________**Phone No.**________________________

Signature of Physician________________________**Date**________________________

Taxpayer Identification Number________________________

Payroll / Store Manager see back of form ➔

D-A&B (100107)

To be completed by PAYROLL

Employer's Name____________________ Member's date of hire____________________

Date Member last worked____________________ Avg. Weekly wage-previous 4 weeks____________________

Is Member still absent?____________________ If not, give date returned to work____________________

Did Member receive any vacation pay during this time?____________________

Is absence a result of an occurrence which took place on the job? ____________________

Has an incident been filed/reported to Workman's Compensation?____________________

Form completed by____________________ Date__________ Title____________________

To be completed by STORE MANAGER or SUPERVISOR

Is absence a result of an occurrence which took place on the job? ____________________

Has an incident been filed/reported to Workman's Compensation?____________________

Describe Injury:____________________

Date of Injury:____________________ Last Day Worked:____________________

Estimated date of return:____________________

Signature and Title:____________________ Date:____________________

****It is required all sections are completed before claim can be considered.****

OPEIU/13
2007

Accident Information: