SAN FRANCISCO ELECTRICAL WORKERS HEALTH AND WELFARE TRUST FUND
720 Market Street, Suite 700, San Francisco, CA 94102
Phone (415) 263-3670 ♦ Fax (415) 263-3672

APPLICATION FOR DISABILITY HEALTH & WELFARE COVERAGE

To qualify, your disability must have commenced while Active member coverage is in force (excluding coverage through COBRA payments) and you must provide certification by your Attending Physician that your disability which prevents you from being able to perform the duties of your regular occupation covered under an IBEW Local 6 collective bargaining agreement has continued for at least thirty (30) days. This application must be submitted no later than ninety (90) days from the date your Active Member Eligibility from hours worked or hourbank reserves runs out.

NAME: _____
Last First Middle

LAST FOUR DIGITS OF SOCIAL SECURITY NO. XXX-XX-_____

I AM RECEIVING: ☐ Workmen's Compensation ☐ Unemployment Disability Insurance

Date Disability Began: _____ *(Please attach Physician's Statement of Disability)*

I understand that continuation of coverage due to disability does not begin until after the expiration of my reserve hours and will continue during my disability for a period not to exceed the lesser of:

1. 12-months; or

2. the number of months of Active member eligibility supported by hours worked, hourbank reserves, and COBRA payments during the 12-month period preceding the later of:

    a) the date of the onset of disability; or

    b) the date my Active member eligibility ran out.

I understand that eligibility for the first six months of coverage under this provision is extended at no cost and that if I remain disabled and eligible for additional coverage following the sixth month, I will be eligible for a reduced COBRA monthly coverage payment for up to six months. Further, once my coverage ends as a result of disability, I may continue making COBRA payments at the full unsubsidized rate up to a maximum of 18 months of reduced and unsubsidized COBRA coverage payments. I understand that coverage will cease if any payment that is due, is not received within 30-days after the date I am notified that I am eligible following submission of a completed application, or if a subsequent monthly payment is not received within 30-days from the date I am billed for this coverage.

Note: Limited 3-month Extension: Extended coverage due to disability may be extended for up to 3-months following the month of recovery to allow time to accumulate the necessary hours to re-qualify for eligibility under the Plan, but in no event beyond the maximum periods described above.

_____ _____
Signature Date

_____
Print Name