SAN FRANCISCO ELECTRICAL WORKERS LONG TERM DISABILITY
720 Market Street, Suite 700, San Francisco, CA 94102
(415) 263-3670 • FAX (415) 263-3672

DISABILITY CLAIM NOTICE Form A

Items (1) through (8) below must be completed before application can be processed.

PART 1. CLAIMANT'S STATEMENT

(1) Name of Claimant (Please Print) ______________________ Date of Birth ______________ **Soc. Sec. No.** ______________
(Last) (First) (Middle Initial)

(2) Home Address ______________________ Marital Status: ☐ Single ☐ Married
(Number and Street)

______________________ Tel. No. ______________________
(City) (State) (Zip Code)

(3) Last Employer ______________________ HOME LOCAL UNION NO. ______________
(Name)

______________________ WORK LOCAL(S) ______________________
(Number and Street) (36 mos. Prior to Disability)

______________________ ☐ Foreman ☐ Journeyman ☐ Apprentice
(City) (State) (Zip Code)

(4) How long employed? ________ years ________ months ______________________
(Employer's Phone No.)

(5) If an accident was involved, when did it happen? Date ______________________

(6) When did you start working for Local 6 employers? Date ______________________

(7) Date disability began ______________ 20 ______ Last day actively at work ______________ 20 ______

(8) Date returned to work ______________ 20 ______

APPLICANT: Please read carefully as the following makes you liable for payments made to you in excess of those authorized by the Plan.

BENEFITS IMPROPERLY PAID: Any benefit paid to a person not entitled thereto shall be owed by him to the Trust. Notwithstanding any other provision of this Trust, overpayments shall be deducted from future benefits payable to the recipient unless the Administrative Committee concludes that requiring such repayment would be inequitable under the circumstances of the case.

I further agree that, if I do not make such restitution and the Trust institutes legal action to collect any sums owed to it, I will be liable to the Trust not only for such sums, but also for all costs and expenses, including reasonable attorney's fees.

I, hereby agree that, in the event it is later determined that I received more Long Term Disability Benefits than I was entitled to, I will, upon demand by the Electrical Workers Long Term Disability, make restitution in the amount of any such overpayment. I will disclose any retroactive or lump sum payments of the above or related benefits.

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief, true, correct, and complete. I hereby authorize any physician, or any hospital, to furnish and disclose all known facts concerning this disability. A copy or photocopy of this authorization shall be as valid as the original. The Trust at its own expense shall have the right and opportunity to examine the person when and as often as it may require during the pendency of a claim hereunder.

Employee's Signature ______________________ Date of Claim Signed ______________________