AUTOMOTIVE INDUSTRIES WELFARE FUND

DISABILITY PLAN – BENEFIT CLAIM

INSTRUCTIONS FOR FILING CLAIM
1. Employee completes Part I
2. Employer completes Part II
3. Doctor completes Part III
4. Send claim to administration office

Claim must be submitted within 180 days of your disability start date

4160 DUBLIN BLVD., STE. 400, | DUBLIN, CA 94568
PHONE: (800) 635-3105 | FAX: (925) 588-7121

IMPORTANT:
Please attach a copy of a check stub or statement provided to you by State Disability or Worker's Compensation, showing your weekly benefit entitlement. Failure to do so may delay your benefit payments.

PART I. TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT ALL ANSWERS)

LAST NAME	FIRST NAME	INIT.	DATE OF BIRTH	SOCIAL SECURITY NUMBER

YOUR MAILING ADDRESS (NUMBER AND STREET, CITY, SATE, ZIP)	YOUR PHONE NUMBER

NAME OF COMPANY YOU WORK FOR	NAME OF YOUR DIRECT SUPERVISOR	EMPLOYER PHONE NUMBER

COMPANY'S PHYSICAL ADDRESS	LOCAL UNION NUMBER

CHECK REASON FOR DISABILITY:

☐ ILLNESS ☐ ACCIDENT

MUST BE ANSWERED IF CLAIM IS FOR AN ACCIDENT:
DATE OF INJURY?_____ WHERE DID INJURY OCCUR?_____
HOW DID INJURY OCCUR _____
IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF EMPLOYMENT? ☐ YES ☐ NO

CIRCLE ALL OF YOUR REGULARLY SCHEDULED DAYS OF WORK DURING THE WEEK:
SUN. MON. TUES. WED. THURS. FRI. SAT.

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief, true and correct and complete. I hereby authorize any physician, any hospital, the disability plan manager, or any worker's compensation carrier to furnish and disclose all facts concerning this disability. A copy or photocopy of this authorization shall be valid as the original. I agree that i will report all benefit amounts I am receiving, or entitled to receive, because of my disability. I understand that I must give written notice to the administration office when I recover from my disability, or when I become self-employed or employed by anyone.

EMPLOYEE SIGNATURE_____ **DATE** _____

PART II. TO BE COMPLETED BY THE EMPLOYER (PLEASE PRINT ALL ANSWERS)

1. EMPLOYEE'S JOB CLASSIFICATION?_____
2. NUMBER OF HOURS EMPLOYEE USUALLY WORKS PER WEEK _____
3. EMPLOYEE'S PRESENT HOURLY GROSS WAGE RATE (EXCEPTING OVERTIME) _____
   PLEASE INCLUDE ANY REGULAR SHIFT DIFERENTIAL OR FOREMAN PAY IN THE GROSS HOURLY WAGE RATE ABOVE
4. DOES YOUR CURRENT UNION CONTRACT PROVIDE FOR A "DISABILITY CLAUSE" THAT REQUIRES THE EMPLOYER TO PAY HOLIDAY PAY IF THE EMPLOYEE IS TOTALLY DISABLED DURING HOLIDAYS? ☐ **YES** ☐ **NO**
   IF YOUR ANSWER IS "YES", PLEASE ATTACH A COPY OF THE "DISABILITY CLAUSE" PROVIDED IN YOUR MOST CURRENT COLLECTIVE BARGAINING AGREEMENT. FAILURE TO DO SO MAY DELAY DISABILITY BENEFITS FOR YOUR EMPLOYEE.
5. LAST DATE EMPLOYEE WORKED _____
6. IF EMPLOYEE WAS PAID SICK OR VACATION PAY, DURING DISABILITY, PLEASE CHECK ONE: ☐ **SICK PAY** ☐ **VACATION PAY** ☐ **N/A**
7. IF EMPLOYEE WAS PAID SICK OR VACTION PAY, PLEASE LIST DATES PAID_____
8. DATE OF FIRST SCHEDULED WORK DAY EMPLOYEE WAS DISABLED FOR WHICH ***NO WAGE*** WAS PAID_____
9. DATE EMPLOYEE RETURNED (OR IS EXPECTED TO RETURN) TO WORK _____
10. IF EMPLOYEE HAS NOT RETURNED TO WORK, IS EMPLOYEE EXPECTED TO RETURN TO WORK FOR YOU? ☐ **YES** ☐ **NO**
    IF YOU CHECKED "NO", PLEASE INDICATE REASON FOR YOUR STATEMENT _____

I realize that all information shown in parts i and ii will be used as a basis for determining disability benefits, if any, and hereby declare and certify that the foregoing statements are, to the best of my knowledge and belief, correct and true.

SIGNED BY_____ PRINTED NAME_____
TITLE_____ DATE SIGNED_____
COMPANY NAME AND ADDRESS_____
PHONE NUMBER_____

PART III. TO BE COMPLETED BY THE DOCTOR (PLEASE PRINT ALL ANSWERS)

"Doctor" means doctor of medicine(MD) or osteopathy (DO), and while practicing within the scope of his license, includes chiropractor, dentist, optometrist, podiatrist, psychologist, and upon referral by a MD or DO, a licensed clinical social worker.

1. DIAGNOSIS (INCLUDING ICD-10 CODES)	2. DATE PATIENT FIRST CONSULTED YOU FOR THIS DISABILITY?	3.WAS CLAIMANT HOSPITAL CONFINED AS A REGISTERD BED PATIENT? ☐ **YES** ☐ **NO** DATE ENTERED_____RELEASED_____

4.CLAIMANT IS/WAS CONTINUOUSLY DISABLED FROM_____THROUGH_____	5. IF STILL DISABLED, DATE CLAIMANT SHOULD BE ABLE TO RETURN TO WORK:	6. IF ANSWER TO NO, 5 IS UNKOWN, WHEN IS CLAIMANT'S NEXT APPOINTMENT DATE?

7. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? ☐ YES ☐ NO

DOCTOR'S NAME AND DEGREE (PRINT):	DOCTOR'S SIGNATURE:	DATESIGNED:

DOCTOR'S STREET ADDRESS:	DOCTOR'S OFFICE PHONE NUMBER:

** ANY FEE FOR THIS INFORMATION IS NOT CHARGEABLE TO THE TRUST**
NOTE: ANY PERSON OR PERSONS MAKING A WILLFUL MISREPRESENTATION IN COMPLETING THIS FORM, SHALL BE LIABLE TO THE TRUSTEES FOR ANY LOSS TO THE FUND RESULTING FROM SUCH MISREPRESENTATION.