UFCW LOCAL 655
WELFARE FUND
300 Weidman Road, Suite A
Ballwin, Missouri 63011
Phone | 314.835.2700 or 1.866.565.2700
Fax | 314.835.2790 | WWW.655HW.ORG

Important Information Regarding the Weekly Disability Benefit

How to Qualify for Weekly Disability Benefit

- **Visit a physician within the first three days of illness or injury;**
- **Be eligible for benefits at the time of disability;**
- **Be wholly and continuously disabled and unable to perform the duties of your occupation;**
- **Be under the care of a legally qualified physician;**
- **The service/treatment must be a covered benefit under the Welfare Fund guidelines;**
- **Your Physician must include an approximate date of return to work when completing the original disability form. We cannot accept your claim if physician states "unknown;"**
- **Reinstatement of weekly disability benefits are restored when you return to work and work your average weekly hours (minimum of 25-32 hours per week based on your date of hire for Unit 1 eligibility qualification).**

Maternity Weekly Disability Benefit

If you are disabled prior to date of delivery the benefit will not exceed the maximum of 13 weeks.

If disability is due to maternity, the maximum time allowed is as follows:

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

Weekly Disability Wage

The Weekly Disability Income Benefit is payable for a maximum of 13 weeks during any one period of disability.

- **One week of disability pay is a period of seven days, including the weekend;**
- **Benefits begin the 1st day of an accident or the 4th day of a sickness;**
- **The weekly benefit amount is 70% of the average base pay you received during the four weeks immediately preceding the disability; with a maximum of $600 per week.**

- **If you return to work prior to the date your physician released you, please contact the Fund office at 314-835-2700.**
- **If you return to work before the 13 week disability extension is completed, contributions paid for hours worked will override the extension of benefits and premium share deductions may be applied.**

Please see page 57 of your Summary Plan Description (2018 edition) for more information regarding the Weekly Disability Benefit.

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Weekly Disability Benefit Form

Important Instructions

- **Please complete the member, physician, and employer sections accordingly when the disability claim is related to a sickness/illness.**
- **Please have all sections completed accordingly plus the Disability-Accident Questionnaire when the disability claim is related to an accident/injury that occurs outside of the home or if a third party is involved.**
- **Payment and/or Benefit Extension cannot be granted until all applicable sections are completed.**

Member's Section
(To be completed by member)

Clear ALL Forms

Member's Name	Date of Birth	Social Security # or Plan ID

Member's Address

Member's Phone #	Member's E-mail Address	Employee ID through Employer

Disability Type

◯ Sickness/Illness
Please be sure to have all three sections (member, physician and employer) completed accordingly.

◯ Accident/Injury/Third party/ Workers' Compensation claim
Please be sure to have all three sections (member, physician and employer) completed accordingly, plus the Disability-Accident Questionnaire that is enclosed.

◯ Pregnancy (Due date:_____)
Please be sure to have all three sections (member, physician and employer) completed accordingly.

Description of sickness/illness and/or injury:

_____

_____

Were you employed when your initial disability occurred

◯ Yes (Employer name and phone#:_____ _____) ◯ No

What is your job title?	Was this disability caused by a third party? ◯ Yes ◯ No

Was this disability a result of your employment? ◯ Yes ◯ No	If this disability was a result of your employment, have you filed a Workers' Compensation claim? ◯ Yes ◯ No

If you filed a Workers' Compensation claim, has your employer accepted responsibility for this diagnosis?

◯ Yes ◯ No

For the purpose of determining eligibility for benefits and claim processing, I hereby authorize United Food & Commercial Workers Local 655 Welfare Fund to receive from and/or provide ALL FORMS AND DOCUMENTS RELATED TO THIS DISABILITY BENEFIT FORM to any licensed physician, clinic, hospital, or other medical related facility, insurance company, or other person, organization, EMPLOYER, or institution information as to any physical or mental condition of myself or my covered dependents when the information is needed for treatment, payment or operations.

I hereby certify that the above information is true and correct to the best of my knowledge. I understand that a falsification or withholding of material facts may result in loss of benefits. I agree a photographic copy of this authorization is as valid as the original.

Member's Signature: Date:

YOU MAY FAX THIS FORM TO 314.835.2790 OR LOG INTO YOUR PARTICIPANT PORTAL AT WWW.655HW.ORG AND SEND YOUR FORM DIRECTLY TO YOUR WELFARE FUND FILE BY USING THE "FORM UPLOAD" FEATURE

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Direct Deposit Authorization Form

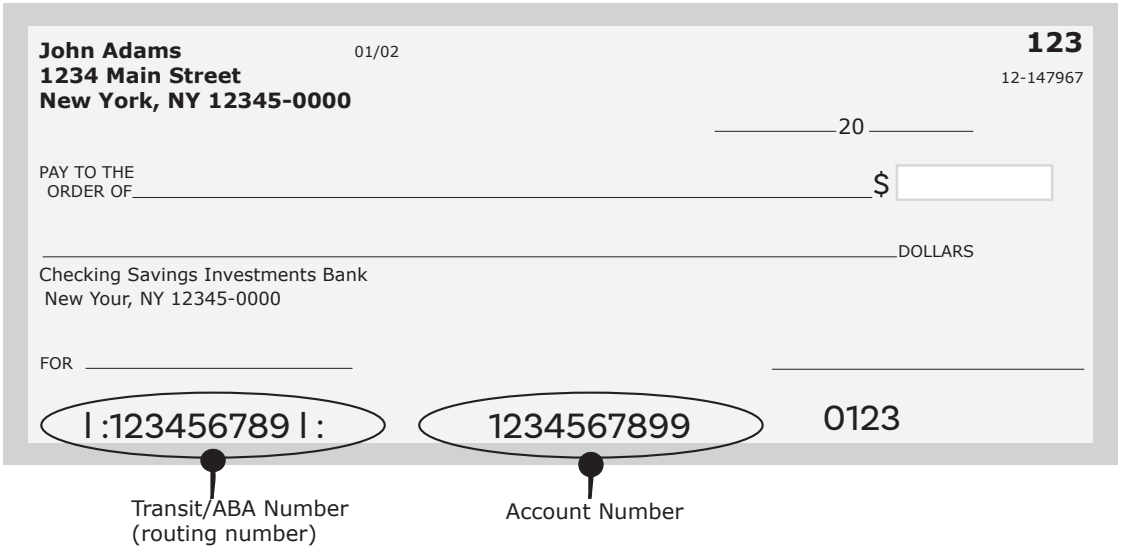
By completing and signing this form, I hereby authorize UFCW Local 655 Welfare Fund, to deposit with the financial institution noted below, to my account, any amounts due to me from the Fund, and to debit or adjust my account for any credit entered in error. I understand that short-term disability payments are payable to me only during my lifetime. I, therefore, authorize and direct the bank designated herein to charge my account for any payment made after my death and to refund any such payment to UFCW Local 655 Welfare Fund. I understand this Direct Deposit Authorization shall remain valid until I notify UFCW Local 655 Welfare Fund. I understand that UFCW Local 655 Welfare Fund reserves the right to terminate this payment method and my participation in this service at any time.

Participant's Signature _____ Date _____

Participant's Name	Date of Birth	Social Security # Policy Holder's ID
Participant's Address		Participant's Phone #

FINANCIAL INSTITUTION (BANK) INFORMATION

Financial Institution	
Branch	Account Type (Select One): ◯ Checking ◯ Savings
Transit/ABA Number (Routing Number)	Account Number



Please return this form with a voided check to:

300 Weidman Road, Suite A Ballwin, Missouri 63011

Log into your participant portal at www.655hw.org and send your form directly to your Welfare Fund file by using the "FORM UPLOAD" feature.

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Physician's Section

(To be completed by disabling physician)

Patient's Name	Date of Birth	Social Security # or ID #:

Diagnosis Code(s):

Narrative:

Date patient first consulted you for this condition:	Has patient ever had same or similar symptoms? ◯ Yes ◯ No

Was patient hospitalized or seen in ER for this condition? ◯ Yes ◯ No	Is condition related to patient's employment? ◯ Yes ◯ No

Patient was continuously disabled/unable to work (**a from and through date must be listed in order for the Fund to process this claim**):

From: **Through:**

If disability is due to pregnancy, please list expected date of delivery:

Date patient is expected to be released to return to work without restrictions:

Next appointment date:	Physician's Name (**print please**):

Physician's Office Phone#:	Physician's Office Fax#:
Physician's Signature:	Date:

Additional Comments

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Weekly Disability Benefit Form

▶ Effective 3/1/2015 participants are eligible to collect vacation/sick pay from their employer while collecting short term disability benefits. Although this will not affect the disability pay, the Welfare Fund will still require this information to be documented below.

Employer's Section

(To be completed by employer's payroll office)

Employee's Name	Date of Birth	Social Security #

Employee's Address

Employee's Phone #	Employer's Name	Employer's Phone #

Employee's Hire Date	Employee's Last Day Worked Prior to Disability

Average Weekly Wage for the Previous 4 Weeks From Last Day Worked:

Has the Employee returned to work? ◯ Yes ◯ No

If yes, please list return to work date:

Did participant receive any vacation or sick pay during the disability period? ◯ Yes ◯ No

If yes, please list number of hours paid and dates the vacation/sick was applied:

Is participant's absence a result of any occurrence which took place on the job? ◯ Yes ◯ No

If yes, has the incident been filed/reported to Workers' Compensation? ◯ Yes ◯ No

Has the employer taken responsibility for this incident? ◯ Yes ◯ No

Signature and Title of Company Official	Date	Phone

Additional Comments

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Disability-Accident Questionnaire

Important Instructions

- **If your short-term disability claim is for an accident/injury that occured outside of the home, including but not limited to an injury/accident that occured at your place of employment, please complete this questionnaire in its entirety.**
- **Accident Questionnaire must be notarized by a notary public.**

Disability-Accident Questionnaire

(To be completed by member)

Member's Name	Date of Birth	Social Security # or Plan ID

Member's Address

Member's Phone #	Member's E-mail Address	Employee ID through Employer

What part of your body do you have problems with?

What are your symptoms?

When did you begin to notice these symptoms?

Do you feel your symptoms are from an outisde activity? ◯ Yes ◯ No

If Yes, please describe in detail:

Have you discussed your symptoms with a physician? ◯ Yes ◯ No

If Yes, please describe in detail:

Do you have a history of diabetes? ◯ Yes ◯ No

Do you have a history of thyroid abnormalities? ◯ Yes ◯ No

Are you a smoker? ◯ Yes ◯ No

If Yes, how much per day?

Continue

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Disability-Accident Questionnaire

If female, have you gone through menopause? ◯ Yes ◯ No

If Yes, when?

_____

Do you take replacement therapy? ◯ Yes ◯ No

Is your disability the result of an accidental injury? ◯ Yes ◯ No

If Yes, please complete questions **1-5** below:

1. **When did the injury/accident occur?** _____
2. **Where did the injury/accident occur?** _____
3. **Was this injury/accident caused by anyone other than yourself?** ◯ Yes ◯ No
   If Yes, please explain in detail.

   _____

   _____
4. **Was this injury/accident a result of a motor vehicle accident?** ◯ Yes ◯ No
5. **Is the treatment for this injury/accident covered under any third party liability insurance?** ◯ Yes ◯ No

Is your disability the cause of an unexpected traumatic event or unusual strain caused by a specific event during your scheduled work shift? ◯ Yes ◯ No

If Yes, please complete **1-9** below:

1. **What is your job description?** _____
2. **How long have you been in this position?** _____
3. **Are you considered full-time or part-time?** _____
4. **How many hours per week do you work?** _____
5. **What are they physical requirements of the job (please give specifics)?** _____

   _____
6. **Have you reported your symptoms to your employer as a possible Workers' Compensation injury?** ◯ Yes ◯ No
7. **Has your employer sent you to a doctor?** ◯ Yes ◯ No
   If Yes, please provide name and phone number: _____
8. **Have you seen a doctor on your own?** ◯ Yes ◯ No
   If Yes, please provide name and phone number: _____
9. **Do you intend to pursue/litigate this diagnosis to a higher level?** ◯ Yes ◯ No

By signing below, I hereby authorize any employer, insurance company, any information, including medical history or treatment that is necessary to determine benefits paid or payable concerning this claim or other claim related to this condition. I certify that the above information is true and correct. I understand that any intentional false statement made herein may void my coverage at the sole option and will void the rights to benefits otherwise available to me and my dependents. In such event, I agree to reimburse for any benefits received by me or my dependents to which we were not entitled.	**Notary: Please affix seal here**
Member's Signature	Notary Public's Signature or Welfare Fund Office Employee's Signature
Date	Date

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