Sheet Metal Workers' Health Plan of Southern CA, AZ & NV P.O. Box 10067, Manhattan Beach, CA 90266 1-800-947-4338 or 1-310-798-6572

Unable to work due to an injury or illness?

You may qualify for an extension of your eligibility for benefits.

According to the rules of the Plan, if an active employee becomes disabled for a period of at least 7 consecutive days, he may apply for Disability Hours credit. In order to qualify for Disability Hours Credit, <u>all</u> of the following requirements must be met:

- 1. The disability must be due to injury or illness which prevents the employee from performing the normal duties of his occupation.
- 2. The disability must be certified by a licensed Physician (M.D.).
- 3. The written certification of disability must be submitted to the Administrative Office no later than 30 days following the date the employee became disabled. (Form enclosed).
- 4. The employee must have been eligible, other than as COBRA or self-pay, during the month in which he became disabled.

The maximum number of disability hours that can be credited during a calendar month is 110. Disability hour's credit may be given for a maximum of 13 weeks in any twelve consecutive calendar months period.

Please complete the employee portion of the **enclosed Evidence of Disability Form**, have your doctor complete the "Attending Physician Statement", and **return the completed form to the Administrative Office** immediately.

Upon the Administrative Office's receipt of a completed Evidence of Disability Form, your Hour Bank may be credited with Disability Hours at a rate of 27.5 hours for each week you are disabled, to a maximum of 13 weeks (357.50 hours).

At the expiration of the maximum disability crediting period, or earlier, should recovery from disability occur, any hours left in your Hour Bank will be used to continue eligibility.

If you are still disabled or unemployed at the time your eligibility ceases, you may be entitled to continue your coverage by either: 1) enrolling in the Disabled or Unemployed Self-pay Program at a reduced benefit level (Plan B), or, 2) continue your current Plan A level of benefits under COBRA. If you choose to enroll in the Self-Pay Program, a completed application and check in the amount of \$250 must be received in the Administrative Office no later than the 20th of the month prior to the month of coverage.

If you have any questions regarding this matter, please contact the Eligibility Department of the Administrative Office at 1-800-947-4338.

Sheet Metal Workers' Health Plan P.O. Box 10067 Manhattan Beach, CA 90266 Phone 1-800-947-4338 or 310-798-6572 Fax 310-798-0766

Evidence of Disability Form

To be completed by employee: PLEASE! Print

Street Address		M.I.	Date of Birth ZIP Code	Social Security Number			
				Phone Number			
		State		Local Union Number			
Name of Employer				Employer's Phone Numbe			
Occupation &	Employment Status at time of Dis	sability		Full Time Part Time			
s no	Is this disability due to occupat	ional cause or	causes?				
	Has a claim been filled for Workers' Compensation?						
l 🗆	Will such a claim be filed?						
escribe Disab	pility:						
/as an accider	nt involved? Yes No						
	If "YES", date and time of accident occur?	lent:					
	Describe the accident in Detail?						
ll the above a	enswers are true and correct to the	e best of my F	knowledge:				
Employee Signature				Date Signed			

Please also sign and date the Authorization to Release Information on the reverse side of this form

Authorization for Release of Information

I authorize any physician, medical practitioner, hospital, Veteran's Administration hospital, clinic, other medical or medically related facility, insurance company, consumer reporting agency, employer or group policy holder having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me or my minor children, to give Sheet Metal Workers' Health Plan or it's legal representative, any and all such information.

I understand that the information obtained by use of the Authorization will be used by Sheet Metal Workers' Health Plan to determine eligibility for an extension of my health coverage or the Disability Self-Pay plan. Any information will not be released by the Sheet Metal Workers' Health Plan to any other person or organization.

I know that I may request a copy of this Authorization. I agree that a photo copy of this Authorization shall be as valid as the original. I agree that this Authorization shall be valid for two and a half years from the date shown below.

Empl	oyee's Signature		Date							
1)	Diagnosis & concurrent conditions (I	•	Physician Staten de other that ICI		name)					
2)	Is condition due to injury or sickness arising out of patient's employment? Pregnancy?									
3)	Dates of Services:									
4)	Date symptoms first appeared or accident happened:									
5)	Date patient first consulted you for this condition?									
6)	Has patient ever had same or similar condition?									
7)	Is patient still under your care for this condition?									
8)	Patient was continuously totally disabled (unable to perform their normal Sheet Metal duties) from to									
9)	Patient was partially disabled from		to							
10)) If still disabled, patient should be able to return to work:									
11)	Patient was house confined from		to							
12)	Hospitalization dates:									
13)	Does patient have other Health Cov	erage?	If yes, identi	fy:						
Date	Physician's Name (<i>print</i>)	Physician's	Signature	Deg	gree	Telephone				
Stre	et Address	City		State		Zip Code				