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, all 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 100. Disability hours 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 25 hours for each week you are disabled, to a maximum of 13 weeks (325 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 on a self-pay basis in accordance with the regulations of COBRA. A COBRA Continuation Coverage Notification will be automatically sent to you upon your termination of active coverage.

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

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Phone 1-800-947-4338 or 310-798-6572 Fax 310-798-0766

Evidence of Disability Form

To be completed by employee: *PLEASE! Print*

Name: Last First M.I. Date of Birth Social Security Number

Street Address Phone Number

City State ZIP Code Local Union Number

Name of Employer Employer's Phone Number

Occupation & Employment Status at time of Disability ☐ Full Time ☐ Part Time

YES	NO	
☐	☐	Is this disability due to occupational cause or causes?
☐	☐	Has a claim been filled for Workers' Compensation?
☐	☐	Will such a claim be filed?

If "YES" to any of the above, Name of Workers' Compensation Carrier: _____

Describe Disability:

Was an accident involved? ☐ Yes No ☐

If "YES", date and time of accident: _____
Where did accident occur? _____
Describe the accident in Detail? _____

All the above answers are true and correct to the best of my knowledge:

*Employee Signature Date Signed

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

THE ATTENDING PHYSCIAN MUST COMPLETE AND SIGN 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.

Employee's Signature Date

Attending Physician Statement

1) Diagnosis & concurrent conditions (If diagnosis code other that ICDA used, give 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 Coverage? If yes, identify:

Date Physician's Name ***(print)*** Physician's Signature Degree Telephone

Street Address City State Zip Code