**Sheet Metal Workers' Health Plan**
Of Southern CA, AZ & NV
P.O. Box 10067, Manhattan Beach, CA 90266
Phone 800-947-4338 Fax310-798-0766
***Attn: Eligibility Department***

## Application for EXTENSION of Unemployed/Disabled Self-Pay Coverage

**Please PRINT clearly:**

Name: ______________________________ Last 4 Digits of SSN: ______________________________

Address: ______________________________ Phone #: ______________________________

______________________________ Local Union: ______________________________

Are you currently on the Local Union's "Out-Of-Work" List and available for covered employment? [ ] YES [ ] NO

When were you last referred to a Sheet Metal Job? ______________________________

Did you accept it? [ ] YES [ ] NO If not, why? ______________________________

______________________________________________________________

Are you currently employed? [ ] YES [ ] NO If yes, provide the name & address of your current employer and your job duties:

Employer Name: ______________________________

Address: ______________________________

Job Duties: ______________________________

Are you currently unable to work due an injury or illness? [ ] YES [ ] NO
**If YES, please attach proof of disability**.

Please provide any other information you believe relevant: ______________________________

______________________________________________________________

I understand that Unemployed/Disabled Self-pay coverage is available for up to 6 consecutive months (dependent on prior use). I understand that all payments are due in the Administrative Office **no later than the 20th of the month PRIOR to the month of coverage**. The Administrative Office does NOT send bills or reminder notices. **Failure to remit payments by the due date will result in termination of coverage**. Once terminated, Self-pay coverage cannot be reinstated. **I also understand that should I return to work, there is a full calendar month between work month and coverage month.**

I certify that all the above answers are true and correct to the best of my knowledge.

______________________________ ______________________________
***Signature*** ***Date***

***** In no event will Self-pay coverage be provided for more than 12 consecutive months *****

***Please contact the Eligibility Dept. at the Administrative Office if you have any questions.***

---

Local Union Verification: ______________________________ Date: ______________________ rev 6/17