DISABILITY CLAIM NOTICE

ELECTRICAL WORKERS SAN MATEO COUNTY DISABILITY BENEFIT TRUST FUND
UNITED ADMINISTRATIVE SERVICES, P.O. BOX 5057, SAN JOSE, CA 95150-5057

Please answer all questions fully. This will help avoid unnecessary correspondence.

PART I, CLAIMANT'S STATEMENT

(1) Name of Claimant (Please Print) SOC. SEC. _____

_____ Date of Birth _____ Telephone _____

(Last) (First) (Middle Initial) Marital Status

(2) Home Address _____ ❑ Single

(No. and Street) (City) (State) (Zip) ❑ Married ____/____/____/____/____/____

(3) Employed by _____ IBEW Local No. _____

(4) Did disability arise out of your employment? ❑ Yes ❑ No ❑ Foreman ❑ Journeyman ❑ Apprentice

(5) If an accident was involved, when did it happen? Date _____ 20 _____

(a) Where did the accident occur? _____

(b) Give brief description of accident: _____

(6) Date of beginning covered employment in the electrical industry (Local 6,595,617) _____ 20 _____

(7) Date disability began _____ 20 _____ Last day actively at work _____ 20 _____

(8) Date returned to work _____ 20 _____

(9) Are you receiving or are you entitled to receive benefits from any of the following sources because of this disability or period of absence? (Each question must be answered)

Worker's Compensation	❑ Yes	❑ No	Your own or any other disability			Any Federal, State or		
Social Security	❑ Yes	❑ No	Income Plan	❑ Yes	❑ No	Provincial Agency	❑ Yes	❑ No
State Disability Insurance	❑ Yes	❑ No	Railroad Retirement Act	❑ Yes	❑ No	Other Source	❑ Yes	❑ No

If "Yes," give source of such benefits, amount of benefits and frequency of payment (weekly, monthly or lump sum) _____

_____

_____

APPLICANT: Please read carefully as the following makes you liable for payments made to you in excess of those authorized by the Plan

BENEFITS IMPROPERLY PAID: Any benefit paid to a person not entitled thereto shall be owed by him to the Trust. Notwithstanding any other provision of this Trust, over-payments shall be deducted from future benefits payable to the recipient unless the Administrative Committee concludes that requiring such repayment would be inequitable under the circumstances of the case. I further agree that, if I do not make such restitution and the Disability Trust institutes legal action to collect any sums owed to it, I will be liable to the Trust not only for such sums, but also for all costs and expenses, including reasonable attorneys' fees.

I hereby agree that, in the event it is later determined that I received more Disability Benefits than I was entitled to, I will, upon demand by the Electrical Workers San Mateo County Disability Benefits Trust, make restitution in the amount of any such over-payment. I will disclose any retroactive or lump sum payments made of the above or related benefits.

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief, true, correct and complete. I hereby authorize any physician, or any hospital, to furnish and disclose all known facts concerning this disability. A copy or photocopy of this authorization shall be as valid as the original. The Trust at its own expense shall have the right and opportunity to examine the person when and as often as it may require during the pendency of a claim hereunder.

Please note that to qualify for the Disability Benefits, you CANNOT be registered on the IBEW Local 617 out of work list.

Benefits will stop with the month that any beneficiary accepts a benefit payment from ANY electrical industry Retirement Plan (e.g., NEBF, IBEW, or the San Mateo County Electrical Industry Retirement Trust). Benefit payments will also stop with the first month that a beneficiary starts to receive regular Social Security benefits, (not Social Security Disability benefits).

Date this Claim Signed _____ Employee's Signature _____

Revised 12/17

ELECTRICAL WORKERS SAN MATEO COUNTY
DISABILITY BENEFITS TRUST FUND

Give to physician who first attended you when disability started

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Name of Patient _____ SSN: _____

Present Address _____

Signature of Patient _____ Date _____

ATTENDING PHYSICIAN'S STATEMENT

To be furnished without expense to the Trust:

When did symptoms first appear or accident happen?	Month	Day 20
Date patient ceased work because of disability	Month	Day 20
Date patient was first seen in emergency	Month	Day 20
Date of first attending visit	Month	Day 20
Date of last attending visit	Month	Day 20
How long will patient be continuously totally disabled and unable to work at his trade? (See Job Description below.)	From ❑ Indefinite	Thru _____ (Approximate Date) ❑ Permanently

Diagnosis and Physician's Remarks:

JOB DESCRIPTION

The following job description for Inside Wiremen can be used as a criterion for medical evaluation and analysis of a claimant's disability:

To be an Electrical Industry Inside Wireman requires physical stamina and mental aptitude. Good vision, mechanical ability and finger dexterity are essential. The trade requires climbing, crawling, crouching and working in cramped quarters, carrying loads up to 50 pounds, and the ability to pull wire up to 50 pounds.

Date _____ _____

Physician's Signature