OPERATING ENGINEERS LOCAL 501 SECURITY FUND

Temporary Total Disability

Dear Participant:

The Trust Fund Administrative Office has received notification from your employer that you are currently off work due to a Temporary Total Disability. In order to update coverage we need the Temporary Total Disability Certification to indicate the date your doctor initially placed you off work. Please be advised that in order to maintain your coverage during your Temporary Total Disability *"You must obtain certification of Total Disability from a Physician(M.D.) and complete the necessary "Notice of Total Disability" form and file it with the Trust Fund Administrative Office in order to receive a Total Disability extension."* *See Summary Description Page 20.* Please be advised you are responsible for providing any extensions from your physician in order to maintain coverage.

Per Plan Rules: *"After becoming covered under the Plan, if you cannot work because of a Total Disability, which exists continuously from the date last worked until the date eligibility for coverage under the Plan would terminate based on Employer contributions, you, your Spouse, and your Dependents may extend medical coverage for up to three (3)months at no cost. However this extension coverage does not include dental, vision, or death and AD&D benefits. The Total Disability extension period will be credited against your maximum period of COBRA continuation coverage.*

Please be advised to avoid having to re-qualify for benefits upon your return to work with a participating Employer, you must return within 12 months from the date your coverage under the Plan terminated, and the Employer makes the required contributions, your coverage will begin again on the first day of the calendar month following the calendar month you work at least 72 hours.

Please complete Part I of the enclosed Temporary Total Disability form and **have your doctor complete Part II**. Once completed, please return to the Trust Fund Office. If your disability is extended, you will also need to submit a copy of all doctor extension notes.
If you have any questions, please contact our office.

Sincerely,

Eligibility Department

Mailing Address: P.O. Box 990 ◆ West Covina, CA 91793
Physical Address: 1050 Lakes Drive Suite 120 ◆ West Covina, CA 91790
8311 West Sunset Road Suite 250 ◆ Las Vegas, NV 89113
Phone 626·646·1079 ◆ Toll Free 800·320·0106 ◆ Facsimile 626·931·1368
www.oelocal501benefits.org ◆ staff@oelocal501benefits.org

Operating Engineers Local 501 Security Fund
Temporary Total Disability

Return completed form to:

Operating Engineers Local 501 Security Fund
1050 Lakes Dr. Suite #120
West Covina, CA 91790

Trust Fund Phone #: (626) 646-1079
Toll Free #: (800) 320-0106
Fax #: (626) 931-1368

Part 1 – To be completed by PARTICIPANT (**Each question must be fully answered**)

1. Name _____ 2. Birth date: _____SSN: _____

Street _____ 3. Last date of work before disability _____

City and State_____ Zip code_____ Member's Phone#_____

4. My disability is_____ Injury? _____

Illness? _____

5. It happened: Date_____ at Work? _____

Time_____ At Home? _____

6. How did it happen? _____

7. Job Description? _____

To Physicians, Hospitals and Other Institutions: I hereby authorize you by this form (or by photographic copy hereof) to give Operating Engineers Local 501 Security Fund any information you have regarding my medical history and physical condition.

I certify the above answers are true and complete to the best of my knowledge and belief.

Dated_____ Mr._____ Mrs._____ Miss_____ _____

SIGNATURE – Please Do Not Print

Part II – ATTENDING PHYSICIAN'S STATEMENT

1. Nature of sickness or injury/ICD9 (Describe complications if any) _____

_____

2. Was this sickness or injury caused by patient's employment? Yes_____ No_____

Illness? _____ Injury? _____

Was it aggravated by Patient's employment? If "Yes" explain_____

3. Nature of surgical procedure, if any/CPT (Describe fully) _____

_____

4. Date performed: _____

5. Give dates of treatments:

	FIRST CONSULATION	OTHER CONSULTATIONS DURING THIS PERIOD OF DISABILITY
Office	_____	_____
Hospital	_____	_____

6. The patient has been continuously disabled (unable to work): From_____

Through (if unsure give tentative date) _____

If still disabled, when should patient be able to return to work? _____

7. Remarks_____

Date _____ Physician's Name (Print) _____Degree_____

Physician's Signature_____

Address_____

Physician's Phone Number_____