SHEET METAL WORKERS LOCAL NO. 33
SUPPLEMENTAL UNEMPLOYMENT BENEFIT FUND

PO Box 4450
Troy, MI 48099-4450
Phone: 1-800-851-6024 Fax: (248) 556-2593
Email address: smw33@subfund.org

APPLICATION FOR DISABILITY CLAIM

Name: _____

Soc. Sec. No.: _____ Date of Birth:_____

Address:_____

_____

Telephone Number: _____

Name of Employer at the time disability commenced: _____

Disability Benefit Information:

Disability Carrier Name: _____ Phone: _____

Address:_____
Number and Street City State Zip Code

Claim or Policy Number:_____ Agent:_____

Claims Office:_____

The Following information is required by the Fund Office for processing your claim.

1. The above application must be completed.
2. A medical form completed and filed by the Employee and the Attending Physician.
3. Copies of the Disability Checks you receive from your disability carrier.
4. Additional information needed to process this Disability Claim:

Signature of Applicant:_____ Date:_____