SHEET METAL WORKERS' LOCAL UNION NO. 80
FRINGE BENEFIT FUNDS
P.O. Box 1408 / Troy, MI 48099-1408 / (248) 641-4980 (800) 400-7710

APPLICATION FOR SUPPLEMENTAL AUTO, WORK COMP and JURY DUTY BENEFITS

Applicant's Information

Name: _____

Social Security Number: _____Date of Birth: _____

Address: _____
(Number and Street) (City) (State) (Zip Code)

Telephone Number: _____

Name of your most resent employer: _____

Please choose below the type of Supplemental benefit you are applying for and submit required documents:

____ Auto Related claim for loss of work for illness or injury.
- Must be unemployed for 3 days or more.
- Claim must be filed within 20 days of last date worked.
- Must complete Section A on page 2 and Supplemental Medical claim form on page 4.
- Must provide Auto Carrier check stubs, Carrier information & completed W4.

____ Workers' Compensation claim for loss of work for illness or injury.
- Must be unemployed for 3 days or more.
- Claim must be filed within 20 days of last date worked.
- Must complete Section B on page 2 and Supplemental Medical claim form on page 4.
- Must provide Workers Comp check stubs, Carrier information & completed W4.

____ Jury Duty claim for loss of work.
- Must be unemployed for 2 days or more.
- Claim must be filed within 7 days of last date worked.
- Must provide, "Notice to Appear for Jury Duty", proof of payment & completed W4.
- Must complete Section C on page 3.

A W-4 Tax form must be completed to receive benefits.

Applicant must also provide all required documentation and be eligible under the terms of the S.U.B. Fund's Plan to receive benefits.

If approved, Supplemental Weekly Credit Hours may continue your Health Care eligibility for up to 26 weeks.

Section A – Auto Related Disability

Please be advised that addition to this application the medical claim form on page 4 must also be completed by the applicant, attending physician and last employer.

1. Have you been unemployed for 3 days or more? _____(Yes or No).
2. Have you completed a W-4 Tax form? _____(Yes or No). W-4 Tax form must be completed.
3. Are you being treated by a physician? _____ (Yes or No).
4. Are you receiving or are you entitled to receive weekly compensation benefits from your Auto Carrier for your illness or injury? _____ (Yes or No)
   a. If Yes, then you must attach copies of weekly compensation check stubs.
   b. If No, and you are experiencing delays in receiving benefits from your Auto Carrier, explain the nature of those delays here:

      _____
      _____
      _____

5. Please provide the following information:

   Name of Auto Carrier: _____
   Auto Carrier Telephone number: _____
   Address: _____
   (Number and Street) (City) (State) (Zip Code)
   Claim or Policy No: _____
   Date of illness/injury: _____

Section B – Workers' Compensation

Please be advised that addition to this application the medical claim form on page 4 must also be completed by the applicant, attending physician and last employer.

1. Have you been unemployed for 3 days or more? _____(Yes or No).
2. Have you completed a W-4 Tax form? _____(Yes or No). W-4 Tax form must be completed.
3. Are you being treated by a physician? _____ (Yes or No).
4. Are you receiving or are you entitled to receive weekly Workers' Compensation benefits from your Employer's Workers' Compensation carrier because of an occupational injury or illness suffered while working? _____ (Yes or No)
   a. If Yes, then you must attach copies of weekly compensation check stubs.
   b. If No, and you are experiencing delays in receiving benefits from your Employer's Workers' Compensation carrier, explain the nature of those delays here:

      _____
      _____
      _____

5. Please provide the following information:

   Name of Insurance Co./Workers' Compensation Carrier: _____
   Workers' Compensation Carrier Telephone number: _____
   Address: _____
   (Number and Street) (City) (State) (Zip Code)
   Claim or Policy No: _____
   Date of illness/injury: _____

Section C – Jury Duty

1. Have you been called for and served Jury Duty for two (2) or more days in the State of Michigan? _____ (Yes or No). If yes, a copy of, “Notice to Appear for Jury Duty”, is required.

2. What was the first day you were summon for Jury Duty? _____

3. What was your last day you were summoned for Jury Duty? _____

4. Were you asked to be available or on call for additional services for Jury Duty? _____

   If yes, what was the time frame for additional Jury Duty services? _____
   (Additional court documentations may be required)

5. Have you received a compensation check or checks for being on Jury Duty? _____ (Yes or No). If yes, then you must attach copies of those check stubs.

6. How much was your Jury Duty compensation? $_____
   (_____ per day for _____ days).

CERTIFICATION

I hereby certify that all information furnished by me on this request is, to the best of my belief and knowledge, true and complete. I understand that this completed Application Form will be attached to and become part of my application for benefits.

I hereby state that I am submitting all required documentation with this Application Form or am actively working to obtain the required documentation.

_____ _____

Signature of Applicant Date

SHEET METAL WORKERS' LOCAL UNION NO. 80 INSURANCE TRUST FUND
SUPPLEMENTAL MEDICAL CLAIM FORM

Part 1 – To be completed by the APPLICANT (Each question must be fully answered)

1. Name _____ Birth Date:_____ SSN/Ben ID: _____

Street:_____City and State: _____ Zip: _____

Phone: _____ Email: _____ Last Employer: _____

2. Last day of work before illness/injury: _____ 3. Date illness/injury began: _____

4. Applicant's illness/injury is the result of a claim that is (Choose one): Work related _____ Auto/Motorized Vehicle related _____

Please explain your illness/injury below. If your loss/injury is result of an accident, advise, how, when and where it occurred:

_____

_____

To Physicians, Hospitals and Other Institutions: I hereby authorize you by this form (or by copy) to provide the Sheet Metal Workers Local 80 Fringe Benefit Funds with 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.

Applicant's Signature (do not print): _____Date: _____

Part II – ATTENDING PHYSICIAN'S STATEMENT

1. Nature of illness or injury/ICD-10 (Describe complications if any): _____
2. Was this illness or injury caused or related to patient's employment? Yes _____ No _____
3. Was this illness or injury caused or related to a motorized vehicle accident? Yes _____ No _____
4. Nature of surgical procedure, if any/CPT: _____
5. Date surgery performed: _____ _____
6. Dates of Treatment, indicate first and any following Consultations: _____
7. The patient has been continuously unable to work: From:_____Through _____(if unsure provide tentative date)
8. If still not able to work, when should patient be able to return to work? _____

Physician's Signature: _____ Date: _____

Physician's Name (please print): _____ License: _____

Address: _____Physician's Phone Number: (____) _____

Part III – EMPLOYER'S STATEMENT

1. Employee's Name: _____ Employee's SSN: ____-____-____-_____
2. Last day Employee worked: _____
3. Is the employee's inability to work caused or related to employee's employment? Yes_____No _____
4. Has the Employee filed for unemployment compensation? Yes / No (circle one)
5. Do you know of any circumstances that may affect further payment on this claim? _____

Name of Employer: _____

Signed: _____ Title: _____Date: _____