Administered by BeneSys

U.A. Local No. 393 Benefit Funds

HEALTH & WELFARE, SUB, DEFINED BENEFIT PENSION AND DEFINED CONTRIBUTION

6293 San Ignacio Ave ▪ San Jose, CA 95119 ▪ P.O. Box 2460 ▪ San Jose, CA 95109-2460
(408) 588-3751 ▪ (408) 436-8210 fax ▪ Staff@ualocal393benefits.org ▪ www.ualocal393benefits.org

Short Term Disability
Application Instructions

Short Term Disability is a $150 weekly benefit payable to eligible employees only.

New Claims:

☐ Complete the application on the following page
☐ Complete a W-4 federal tax withholding form
☐ Include the following documentation:

- Proof of disability effective date and expected return to work date (screenshot of EDD website Claim Summary > Claim Information, or similar). If your expected return to work date is later changed, please submit an updated copy to the Benefit Office.
- Proof of receipt of either State Disability Insurance (SDI) or workers' compensation benefits (copy of check stub, screenshot of online payment activity record, electronic benefit payment notification, or similar). The documentation must include your name, the payment period (i.e. 1/15/2024-1/28/2024), and amount paid.

☐ Submit your complete claim to:

U.A. Local 393 Benefit Funds
P.O. Box 2460
San Jose, CA 95109

Fax: (408) 436-8210
Email: sanjosedisb@benesys.com

Continuing Claims:

Submit proof of receipt of either State Disability Insurance (SDI) or workers' compensation benefits (copy of check stub, screenshot of online payment activity record, electronic benefit payment notification, or similar). The documentation must include your name, the payment period (i.e. 1/15/2024-1/28/2024), and amount paid. Send to:

U.A. Local 393 Benefit Funds
P.O. Box 2460
San Jose, CA 95109

Fax: (408) 436-8210
Email: sanjosedisb@benesys.com

Please include your address and telephone number if your contact information has recently changed.

CLAIM FILING DEADLINE: Claims must be submitted within one year of the State Disability Insurance or workers' compensation payment period end date.

Questions? Call the Eligibility Department at (408) 588-3751

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SHORT TERM DISABILITY APPLICATION

PERSONAL INFORMATION

Name: _____ Social Security No.: _____

Date of Birth: _____ Classification: _____

Address: _____

Email: _____ Phone Number: _____

Last Employer: _____ Last Date Worked: _____

My disability is the result of:

☐ Accident/Injury ☐ Illness ☐ Other: _____

I am disabled and unable to work from _____ (date) through _____ (date)

Optional – DIRECT DEPOSIT

Bank Name: _____

Bank Address: _____

Routing Number: _____ Account Number: _____

☐ Checking Account ☐ Savings Account

I hereby apply for Short Term Disability Benefits. I certify the above answers are true and complete to the best of my knowledge and belief. I acknowledge, under penalty of law, that I am entitled to benefits for a particular week only if I am receiving State Disability Insurance or workers' compensation. I understand that this benefit is subject to federal and state income tax.

Participant Signature: _____ **Date:** _____