U.A. LOCAL 393 LONG TERM DISABILITY APPLICATION

To be completed by INSURED EMPLOYEE (Each question must be fully answered)

Name: _____ Soc Sec #:_____
Address: _____ Date of Birth: _____
_____ Phone #: _____
_____ Spouse's Birth Date: _____
Spouse's Name: _____ Spouse's Soc Sec #: _____
Marital Status: _____

My disability is_____ Injury? _____
Illness? _____
It happened: Date_____ At Work? _____
Time_____ At Home? _____
How did it happen? _____
_____

Have you been granted a Social Security Award? ☐ Yes ☐ No
PLEASE ATTACH A COPY OF "SOCIAL SECURITY DISABILITY AWARD LETTER" AND MEDICAL RECORDS.

Information Concerning Disabled Participants

Name of Physician: _____ Date of Treatment: _____
Physician's Address: _____
Diagnosis Code _____ CPT Code _____

To Physicians and Hospitals and Other Institutions: I hereby authorize you by this form (or by photographic copy hereof) to give Local 393 Trust 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 – Do Not Print

I agree to be bound by all Plan Rules and regulations. I understand that I must notify the Trust Fund Office of any change in my personal, marital or employment status. I certify under penalty of perjury that all of the foregoing is true and correct. I understand that the Trustees have the right to recover any payments made to me in error because of any false or misleading statements.

Applicant's Signature: _____ Date: _____

The Long Term Disability Benefit is only payable until you attain age 55. A complete listing of all rules that apply to Long Term Disability can be found on page 48 & 49 of the U.A. Local No. 393 Health and Welfare Formal Plan Rules (as revised January 1, 2006).

Return completed form and documents to: U.A. LOCAL 393 PO Box 2460 San Jose, CA 95109