



SHEET METAL WORKERS' LOCAL 7 ZONE 3
HEALTH & WELFARE FUND
WEEKLY DISABILITY APPLICATION

*Email or fax your completed form for fastest service, or return by U.S. mail to the address below:

SMW 7 Zone 3 Health & Welfare Fund
P. O. Box 547
Troy, Michigan 48099-0547

Phone: (248) 641-4973 / (800) 451-5733
Email: stdisability@benesysinc.com
Fax: (248) 556-2596

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

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

Street: _____ City and State: _____ Zip: _____

Phone: _____ Email: _____ Last Employer: _____

2. Last day of work before disability: _____

3. Date disability started: _____

4. Is your disability work related? ____ Yes ____ No

5. Is your disability the result of: _____ Accident _____ Illness
_____ Surgical Treatment of Degenerative Condition

6. Please explain your Disability. If the result of an accident, advise how, when and where it occurred:

7. Are you receiving or applying for work loss benefits under Michigan worker's compensation, no-fault law, vacation pay or other compensation from your employer during your period of disability?
____ Yes ____ No

8. Weekly Disability Credit Hours will continue your eligibility for up to a maximum of 26 weeks (up to 13 weeks for a work-related disability, or until you begin receiving worker's compensation wage loss benefits). Complete this section for all disability claims.

My Disability is the result of a claim that is:

_____ Non-Work Related _____ Work Related _____ Auto/Motor Vehicle Accident

9. Certification: I certify the above answers are true and complete to the best of my knowledge and belief. I understand that I must repay weekly disability benefits I receive for any week that I receive work loss benefits under Michigan worker's compensation, no-fault law, vacation pay or other compensation from my employer.

Participant Signature (do not print): _____ **Date:** _____

Part II – ATTENDING PHYSICIAN’S STATEMENT

1. Nature of disability/ICD-10 (Describe complications if any): _____

2. Was this sickness or injury caused or related to: patient’s employment or due to a motorized vehicle accident? ___ Yes ___ No
3. Nature of surgical procedure, if any/CPT: _____
4. Date procedure performed: _____
5. Dates of Treatment, indicate first and any follow-up consultations: _____
6. The patient has been continuously disabled (unable to work): **From:** _____ **Through** _____
(if unsure provide tentative date)
7. If still disabled, 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: _____
2. Last day Employee worked: _____
3. Has the Employee filed for unemployment compensation? ___ Yes ___ No
4. Has the Employee filed for worker’s compensation benefits? ___ Yes ___ No
5. Do you know of any circumstances that may affect further payment on this claim?

6. Has the Employee received any vacation or other compensation from your company after the last day Employee worked? _____ Yes _____ No (if so, please describe below)

Name of Employer: _____

Signed: _____ Title: _____ Date: _____

INSTRUCTIONS FOR COMPLETING THE WEEKLY DISABILITY APPLICATION

PART I – To be completed by the Participant

Items 1-9

1. **Participant Information.** This portion is to be completed by the Participant, stating a current address, birth date, and Social Security number or 10-digit alternate ID number; this can be located on your Sheet Metal Workers' Local 7 Zone 3 Health and Welfare Fund identification card.
2. **Last Day Worked before Disability.** Please list the last date you performed any work before your disability commenced.
3. **The First Date Disability Began.** If you have more than one disability date, i.e. you returned to work and are now claiming a new disability or this is related to a prior disability claim, indicate the date of the first day of your new disability date.
4. **Nature of Disability** Please list if your disability is the direct result of an accident or illness that occurred while you were employed and while at work. This information must be provided whether you are filing for any worker's compensation benefits or not.
5. Is your disability the direct result of an accident or due to an illness.
6. **Cause of Disability** If your disability is due to an accident, please state specifically how your accident happened. This Plan excludes coverage for weekly disability benefits if your accident is the result of an occupational injury or job-related illness.
7. **Duplicate Payments** You cannot receive the weekly disability benefit for any week that you receive work loss benefits under Michigan worker's compensation, no-fault law or from your employer or receive other compensation from your employer such as vacation pay. You must reimburse the Fund for if benefits are paid for such periods.

Disability Credit Hours (freezing your banked hours)

8. The Plan will continue your Eligibility, at no cost, for the duration of your disability, regardless of whether your disability is the result of an illness or an injury either on or off the job, or if it is related to a motorized vehicle accident. The Plan will credit you with thirty-five hours (35) for every week you are disabled, up to a maximum period of 52 consecutive weeks. For further information, contact the Benefits Office, or refer to the Plan and Summary Plan Description.

PART II - Attending Physician's Statement – To be completed by your Physician

Items 1-7. This section must be completed in full by the physician who will certify your disability.

7. If your doctor is unable to determine your return-to-work date, an approximate time may be indicated. We will include a disability form with your disability check that is closest to the return-to-work date indicated by your physician. Your doctor will need to complete this form indicating your expected return to work date.

PART III – EMPLOYER'S STATEMENT – To be completed by your Employer

Items 1-5. This section must be completed in full by your last Employer before your disability commenced.