UFCW Bay Area Health and Welfare Trust Fund
UFCW Northern California Health and Welfare Trust Fund
1277 Treat Blvd., 10th Floor – Walnut Creek, CA 94597-8863
Mail: P.O. Box 8086 – Walnut Creek, CA 94596-8086
Telephone: (925) 746-7530 or (800) 794-5678 – FAX: (925) 746-7549

APPLICATION FOR ELIGIBILITY EXTENSION BECAUSE OF TOTAL DISABILITY

INSTRUCTIONS:

1. Return this completed form to the Trust Fund Office **within 60 days** from the date your coverage ended or you received the COBRA continuation notice. If you do not file your application within this 60-day period, you will be disqualified for a Disability Extension.
2. You must have been eligible in the month immediately prior to the work month in which you became disabled. The Plan also requires you to have sufficient qualifying hours to be eligible for benefits. The total required hours can be a combination of hours worked and hours not worked due to disability. The combination of hours worked and scheduled hours not worked must equal or exceed the minimum qualifying hours.
3. If your disability is more than seven calendar days, you must submit proof of your disability. You can request your doctor to complete Part B or you may attach the notifications you received from State Disability or Workers' Compensation for benefits paid to you for the calendar month(s) for which this extension application is made.
4. If your doctor shows a future estimated date of return to work, no further applications for extension are required for any calendar month(s) ending before your future estimated date. Notify your Union Local and the Trust Fund Office if you return to work earlier than the estimated date.
5. You will receive notification from the Trust Fund Office when your application is processed. For additional information about Disability Extensions please refer to your Summary Plan Description.

PART A: Participant to Complete (Please Print)

PARTICIPANT NAME				UNION LOCAL#	SOCIAL SECURITY NUMBER / /
STREET ADDRESS	CITY	STATE	ZIP	BIRTH DATE / /	HOME PHONE NUMBER
LAST EMPLOYER		STORE ADDRESS			
CITY	STATE	ZIP	DATE YOU EXPECT TO RETURN TO WORK / /		STORE PHONE NUMBER

THIS SECTION MUST BE COMPLETED		Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.
	Indicate days and number of hours scheduled to work the first week of disability WEEK OF: _________________							
	Second week of disability WEEK OF: _________________	Sun.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.

I CERTIFY THAT I HAVE BEEN DISABLED AND UNABLE TO WORK AT ANY OCCUPATION IN THE MONTH(S) OF

____. I HAVE/HAVE NOT BEEN PAID VACATION DURING MY DISABILITY.
Circle one

I request that my eligibility be continued due to my inability to work the required hours in the month(s) indicated above because of my total disability. I hereby authorize my doctor to answer the questions contained in this application and to provide any additional information requested by the Trust Fund with respect to my disability.

Signature of Participant ____Date Signed_______________________

PART B: DOCTOR'S CERTIFICATION OF DISABILITY

____________________________________ has been under my care due to____
Name of Patient

and unable to work at any occupation from ______________________________ through _________________________________

If still disabled, give estimated date of return to work ____

Doctor's Signature____ Date_________________________________

____ Degree_________________ I.D. #_______________________
Print or Type Doctor's Name

Address____

City______________________________________ State _________ Zip ______________ Telephone No. ______________________