

**UFCW & Employers Benefit Trust**

**SICK LEAVE CLAIM FORM/DISABILITY EXTENSION APPLICATION**

**You must check one:**  Sick Leave Only  Disability Extension Only  Sick Leave and Disability Extension

Note: Not all Employers offer Sick Leave through the Trust Fund

Have all questions been answered?

Is your Social Security Number correct?

Did your employer complete all questions and give your work schedule?

Are dates of your disability correct?

Did you sign your name?

Did your doctor complete all questions?

| PART A EMPLOYEE INFORMATION  |  |   |   |                                 |                            |  |           |                |                 |                   |
|--|--|---|---|---------------------------------|----------------------------|--|-----------|----------------|-----------------|-------------------|
| Last   |  |   | First   |                                 |                            | Middle Initial   |           |                | Your Soc. Sec.# | Date of Birth     |
| Your name  |  |   |   |                                 |                            |  |           |                |                 |                   |
| Home address   |  |   | Street  |                                 |                            | City   |           |                | State           | Zip               |
| Your telephone #   |  |   |   |                                 |                            |  |           |                |                 |                   |
| Name of store  |  |   |   | Store address                   |                            |  |           | Union Local    |                 | Store telephone # |
| Date of hire   |  | First day absent due to disability  |   | Date you returned to work       |                            | Were you injured on the job?   |           |                |                 |                   |
| NO <input type="checkbox"/> YES <input type="checkbox"/> If yes, date of injury  |  |   |   |                                 |                            |  |           |                |                 |                   |
| PART B EMPLOYER STATEMENT (TO BE COMPLETED BY EMPLOYER ONLY)   |  |   |   |                                 |                            |  |           |                |                 |                   |
| Hours employee is scheduled to work per week   |  |   | Indicate employee's regular schedule for the entire first week of disability. List the number of hours employee was scheduled to work each day. →   |                                 |                            | Sun.   | Mon.      | Tues.          | Weds.           | Thurs.            |
| Straight time hourly rate  |  |   |   |                                 |                            |  |           |                |                 |                   |
| Job classification   |  |   | If employee has returned to work, indicate the number of hours employee worked in the return week. →  |                                 |                            | Sun.   | Mon.      | Tues.          | Weds.           | Thurs.            |
| First day of absence   |  |   |   |                                 |                            |  |           |                |                 |                   |
| Date returned to work  |  |   | Did employee work on first day of paid disability or return to work anytime during this disability? NO <input type="checkbox"/> YES <input type="checkbox"/> If yes, give hours and dates |                                 |                            |  |           |                |                 |                   |
| For Butchers only: Employer Sick leave Exhausted? NO <input type="checkbox"/> YES <input type="checkbox"/> If yes, indicate date last paid.  |  |   | Did employee receive holiday, funeral, birthday or vacation pay during this disability? NO <input type="checkbox"/> YES <input type="checkbox"/> If yes, give hours and dates paid        |                                 |                            |  |           |                |                 |                   |
|  |  |   | Was the employee injured on the job? NO <input type="checkbox"/> YES <input type="checkbox"/> If yes, give hours and dates paid   |                                 |                            |  |           |                |                 |                   |
|  |  |   | During claim period, was employee night crew? NO <input type="checkbox"/> YES <input type="checkbox"/> What was the schedule?   |                                 |                            |  |           |                |                 |                   |
| I, the undersigned, verify that the statements contained herein above under the heading "Employer Statement" are true and correct and I understand that these statements will be presented to the Trustees of the UFCW & Employers Benefit Trust used in support of the above named employee's Sick leave claim. <i>I understand that any false or fraudulent statement made herein may subject me to penalties as prescribed by law.</i>  |  |   |   |                                 |                            |  |           |                |                 |                   |
| Employer's phone number  |  | Date signed   |   | Authorized Employer's Signature |                            |  |           | Title          |                 |                   |
| PART C EMPLOYEE'S STATEMENT  |  |   |   |                                 |                            |  |           |                |                 |                   |
| Were you admitted to the hospital? NO <input type="checkbox"/> YES <input type="checkbox"/>  |  |   | Name of hospital  |                                 |                            |  | Confined  |                |                 |                   |
|  |  |   |   |                                 |                            |  | From: To: |                |                 |                   |
| Did you see a doctor during your disability? NO <input type="checkbox"/> YES <input type="checkbox"/>  |  |   | Describe your disability  |                                 |                            |  |           |                |                 |                   |
| I request Sick Leave payments or Disability Extensions for the days of employment lost because of disability. I understand that I may be subject to civil and/or criminal penalties for committing a fraudulent insurance act if I knowingly provide any materially false information to, or conceal any material facts from, the Trust Fund with the intent to defraud or mislead the Trust Fund to obtain Disability Extensions. I further authorize any physician or hospital to furnish and disclose all known facts concerning my disability. |  |   |   |                                 |                            |  |           |                |                 |                   |
| Date Signed  |  |   | Employee's Signature  |                                 |                            |  |           |                |                 |                   |
| PART D PHYSICIAN'S STATEMENT   |  |   |   |                                 |                            |  |           |                |                 |                   |
| The Patient has been continuously disabled (unable to work)  |  |   | From:   |                                 |                            | Diagnosis  |           | Diagnosis code |                 |                   |
|  |  |   | Through:  |                                 |                            |  |           |                |                 |                   |
| Dates seen by a doctor:  |  | If patient still disabled, give estimated date patient will be able to resume work. |   |                                 |                            | Is disability related to pregnancy? NO <input type="checkbox"/> YES <input type="checkbox"/> EDC _____ |           |                |                 |                   |
| Was patient hospitalized? NO <input type="checkbox"/> YES <input type="checkbox"/>   |  | Name of hospital  |   |                                 |                            | From:  |           |                |                 |                   |
|  |  | City  |   |                                 |                            | Through:   |           |                |                 |                   |
|  |  | State   |   |                                 |                            |  |           |                |                 |                   |
| Signed _____ (Physician)   |  |   |   |                                 | Date Signed _____ (Degree) |  |           |                |                 |                   |
| (Print or type physician's name)   |  |   | (Degree)  |                                 | Address                    |  | City      |                | Phone           |                   |

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**INSTRUCTIONS**

- 1) **Part A and C** – These sections must be completed by the Employee. (For privacy reasons, the Employee may choose to complete Part C **after** the Employer completes Part B.) **Part A** must be completed prior to the Employer completing their section.
- 2) **Part B** – This section must be completed by your Employer. Your Employer may require that only certain authorized signatures be accepted. Please be sure to obtain the proper Authorized Signature. The Employer should indicate the schedule you would have worked had you not been absent due to your disability.
- 3) **Part D** – This section must be completed by your doctor to be paid for the first day of disability or to be paid beyond the first week of disability. In order to be paid for the first day you must be seen by your doctor during your disability. Please be sure your doctor provides the date of office visit. Telephone advice does not satisfy this requirement.
- 4) **Disabled More than Seven Days (Three Days If Disability Caused by Work)** - If you are disabled for more than 7 calendar days (3 days if disability is caused by work) you must file for State Disability Benefits (SDI) or Worker's Compensation Benefits. Attach a copy of your SDI statement of benefits or Worker Compensation Benefit notice to your Sick Leave Claim form. If The Trust Fund receives your claim form without your SDI statement, the Trust Fund will expedite payment for your first week of disability based on estimated SDI benefits. When you receive your SDI or WC benefit notice, mail a copy of the notice to the Trust Fund. If the amount of SDI or WC that you actually received was less than what the Trust Fund estimated, the Trust Fund will reconsider your claim and pay any additional benefits that are due. You will be requested to return any overpayments.

If you fail to file for State Disability Benefits, your Sick Leave benefits will be reduced by the maximum State Disability benefit.

- 5) **Timely Filing Limit** – If you do not file your application by the deadline, you will be disqualified for the Sick Leave Benefit and/or Disability Extension.
  - **Disability Extensions : 60 days** from the date you receive your COBRA/ Loss of Eligibility notification for Disability Extension;
  - **Sick Leave: One year** from the first day of your disability for Sick Leave Claims.
- 6) **Eligibility For Disability Extensions - To be eligible for Disability Extensions;**
  - Your disability must begin during a work month in which you are eligible for benefits.
  - Your total Qualifying Hours can be a combination of hours worked and hours not worked due to disability. The hours you are unable to work because of your disability plus the hours you actually worked, if any, must equal or exceed the minimum monthly Qualifying Hours in order to maintain eligibility.
  - If your disability lasts more than seven calendar days, you must submit proof of your disability. You can request your doctor complete Part D 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.
  - If your Disability Extension Application is granted but you remain disabled when your extension expires, you must file a new application within 60 days from the date the last Disability Extension expired.

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.

**PLEASE MAIL COMPLETED  
FORMS TO:**

UFCW & Employers Benefit Trust  
2200 Professional Dr, Suite 190  
Roseville, CA 95661

Please call Member Service if you have any questions (800) 552-2400.